

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04001

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 12:30AM
<i>Pamela Jean Porter</i>		<i>February 7 2007</i>		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death
<i>Union Memorial Hospital</i>				
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>45</i> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>03 11 1961</i>
Usual Residence of Decedent <i>MD</i>		10a. State <i>MD</i>		10b. County <i>Baltimore</i>
10c. City, Town or Location <i>Baltimore</i>		10f. Zip Code <i>21206</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <i>5902 Willet Avenue</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>2000</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Customer Agent</i>		16b. Kind of Business/Industry <i>DMV</i>
College (1-4 or 5+) <i>2 years</i>				
17. Father's Name (First, Middle, Last) <i>James D. Porter Jr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Evelyn McClendon</i>		
19a. Informant's Name/Relationship (Type, Print) <i>James D. Porter Jr. / Father</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5902 Willet Avenue Baltimore, MD 21207</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Arbutus</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus</i>		Date <i>02 14 2007</i>
21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>		22. Name and Address of Facility Vaughn C. Greene funeral Service <i>8728 Liberty Road, Randallstown MD 21233</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <i>Chronic interstitial lung disease</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
Approximate Interval Between Onset and Death <i>10 years</i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>Michael Lui, M.D.</i>		29c. License number <i>AT2438946</i>		29d. Date signed (Month, Day, Year) <i>February 7, 2007</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael Lui, Union Memorial Hospital, Baltimore MD</i>				
31. Date filed (Month, Day, Year) <i>FEB 12 2007</i>		32. Registrar's Signature <i>Janet A. Spasic</i>		

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04002

1- For
State
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Thelma Pick							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 5:00 PM		
	4a. Facility Name (If not institution, give street and number) Pickersgill			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 213-09-7507	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov. 14, 1917	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Towson 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number 615 Chestnut Ave. Apt. 316			10f. Zip Code 21204			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Edward Thomas Blake					18. Mother's Name (First, Middle, Maiden Surname) Ella Tomasia Bidgood					
	19a. Informant's Name/Relationship (Type, Print) Anita Grooms (daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Green Meadow Drive; Timonium, MD 21093					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hilltop Svc. Corp.			20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Svc. Corp.		Date 2/12/2007	20c. Location - City or Town, State Towson, MD				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 21204							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe Debility								Approximate Interval Between Onset and Death months		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {										
	a. Due to (or as a consequence of): Severe Debility										
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Clostridium difficile colitis, polyneuropathy, rheumatism, multiple strokes, atrial fibrillation, osteoporosis										
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, MD 21204								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D.25205		29d. Date signed (Month, Day, Year) February 12, 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.Riley G.B.M. 6701 N. Charles St. Baltimore MD 21208										
	31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature 								

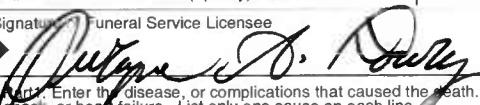
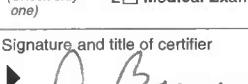
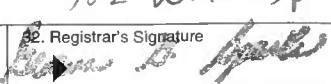
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04003

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NELLIE MAE RAMEY					2. Date of Death Month Day Year FEB. 06 2007	3. Time of Death 2:56 P M					
	4a. Facility Name (If not institution, give street and number) 4607 MAINE AVENUE			4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A						
Funeral Director	5. Social Security Number 190-20-2300		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05/10/1915	9. Birthplace (State or Foreign Country) FLORIDA				
	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 4607 MAINE AVENUE			10f. Zip Code 21207			10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 5TH		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Elementary/Secondary (0-12)			14. Race - American Indian, Black, White, etc. BLACK				
	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry DOMESTIC							
	17. Father's Name (First, Middle, Last) EDWARD BOYKINS					18. Mother's Name (First, Middle, Maiden Surname) LELA JACKSON						
	19a. Informant's Name/Relationship (Type, Print) NELLIE SWIFT / DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4607 MAINE AVENUE, BALTIMORE, MD 21207			20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) DRUID RIDGE CEM.			Date 2/10/07	20c. Location - City or Town, State PIKESVILLE, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD			23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Oesophagia			Approximate Interval Between Onset and Death 1 yr		
Physician /Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 3 Ectopic pregnancy			23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			5 Pending investigation			28a. Date of injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
							28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier 						29c. License number 00059189			29d. Date signed (Month, Day, Year) 2/17/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Serney Barron 702 W. 4th St Baltimore MD 21211											
State Registrar	31. Date filed (Month, Day, Year) FEB 12 2007			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04004

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dalton George Reiber, Jr.							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 9:00 P^M
	4a. Facility Name (If not institution, give street and number) 2219 Graythorn Road			4b. City, Town, or Location of Death Middle River			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 162-16-5919	6. Sex XXM 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct. 14, 1914	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent 10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Middle River		
10e. Street and Number 2219 Graythorn Road				10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Material Handler		16b. Kind of Business/Industry Aero-Space					
17. Father's Name (First, Middle, Last) Dalton G. Reiber, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Stella Baer					
19a. Informant's Name/Relationship (Type, Print) Deborah Wallace (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Southorn Road, Baltimore, Maryland 21220					
20a. Method of Disposition XXBurial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gard.		Date 02/15/2007	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death 2 yrs 5 yrs					
<p>a. <i>Cancer of Kidney</i> Due to (or as a consequence of): <i>Cancer of Kidney</i></p> <p>b. <i>Cardiac Arrest</i> Due to (or as a consequence of): <i>Cardiac Arrest</i></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					
				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D14221					
29b. Signature and title of certifier 				29d. Date signed (Month, Day, Year) 2-12-07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. A. Groves 223 B. Blvd DzL7 MD 21221									
31. Date filed (Month, Day, Year) FEB 12 2007				32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
 amend item 30 per dvr g864 2-12-07 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04005

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stephen M Switzer					2. Date of Death Month 02 Day 03 Year 2007	3. Time of Death 1640 p ^M				
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital			4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George					
Funeral Director	5. Social Security Number 226-76-5941		6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 03/25/1952	9. Birthplace (State or Foreign Country) Maryland			
	10a. State MD		10b. County Prince George		10c. City, Town or Location College Park			10d. Inside City Limits 1 X Yes 2 □ No			
To Be Completed by Funeral Director	10e. Street and Number 4913 Lackawanna St			10f. Zip Code 20740			10g. Citizen of What Country? USA				
	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Service Advisor			16b. Kind of Business/Industry Sports				
	17. Father's Name (First, Middle, Last) Daniel Erden Switzer				18. Mother's Name (First, Middle, Maiden Surname) Jean Burger						
	19a. Informant's Name/Relationship (Type, Print) Georgia Cornell, Significant Other			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4913 Lackawanna St, College Park, MD 20740							
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 02/12/2007	20c. Location - City or Town, State Catonsville, Maryland				
	21. Signature of Funeral Service Licensee ► John S. Weller			22. Name and Address of Facility Fleck Funeral 7601 Sandy Spring RD Laurel Maryland 20707							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
	<p>a. Arteriosclerotic Hypertensive Heart Disease Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 X Probably 4 □ Unknown		
									24a. Was an autopsy performed? 1 □ Yes 2 X No		
									24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 X ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) Feb 12 2007		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) Salvador Sylvester Prince George's County General Hospital						
	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number H0055927			29d. Date signed (Month, Day, Year) February 6, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester Prince George's County General Hospital				32. Registrar's Signature Leanne D. Spake			31. Date filed (Month, Day, Year) Feb 12 2007			

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04006
Reg. No.

1- For State Registrar		1. Decedent's Name (First, Middle, Last) Enid Sullivan								2. Date of Death Month 02 Day 10 Year 2007		3. Time of Death 11:02 PM			
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A					
Funeral Director		5. Social Security Number 220-76-7852		6. Sex 1 □ M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months		If Under 24 Hrs. Hours		8. Date of Birth (Month, Day, Year) July 4, 1923		9. Birthplace (State or Foreign Country) England	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Westminster								10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		10e. Street and Number 30 Timber Ridge				10f. Zip Code 21157				10g. Citizen of What Country? USA					
Physician /Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Domestic									
Medical Certification: To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Frank Holford				18. Mother's Name (First, Middle, Maiden Surname) Alice Fenney									
		19a. Informant's Name/Relationship (Type. Print) Mr. Michael Sullivan (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Fountain Drive York, PA 17402											
Medical Certification: To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation		Date 2/15/2007		20c. Location - City or Town, State Sykesville, MD							
		21. Signature of Funeral Service Licensee Brian C. Haigst		22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400											
Medical Certification: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease								Approximate Interval Between Onset and Death					
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): Coronary Artery Disease b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):													
Medical Certification: To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year									
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
Medical Certification: To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease													
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
Medical Certification: To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State) At home							
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
Medical Certification: To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier Meena Shah MD		29c. License number P18559				29d. Date signed (Month, Day, Year) 2/10/2007							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meena Shah MD 22 South Green Street Baltimore MD 21201													
State Registrar		31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature Meena B. Haigst											

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04007

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan Ethel Smith							2. Date of Death Month Day Year February 8 2007	3. Time of Death 6:30am M
	4a. Facility Name (If not institution, give street and number) Brinton Woods Nursing Center			4b. City, Town, or Location of Death Sykesville			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 218-28-2530	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan 7 1932			9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent 10a. State Md Carroll			10c. City, Town or Location Marriottsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7108 Ridge Road				10f. Zip Code 21104			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) activities director			16b. Kind of Business/Industry health care		
17. Father's Name (First, Middle, Last) Lester C. Parker					18. Mother's Name (First, Middle, Maiden Surname) Nora E. Horn				
19a. Informant's Name/Relationship (Type, Print) Jennie Jones (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7108 Ridge Rd., Marriottsville, MD 21104					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Wards Chapel Cemetery			Date 2-12-07	20c. Location - City or Town, State Marriottsville, MD		
21. Signature of Funeral Service Licensee ► Brian L. Haight				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<p>{</p> <p>a. Due to (or as a consequence of): Chronic Obstructive Lung Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier ► Patrick L.		29c. License number D20806			29d. Date signed (Month, Day, Year) 2/8/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Turner, M.D. 1000 W. Liberty Rd. Eldersburg, MD 21784									
31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature Linda B. Spaulding							

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10 9

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 008

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Stojka							2. Date of Death Month Day Year February 11, 2007	3. Time of Death 7:0AM M	
	4a. Facility Name (If not institution, give street and number) 8607 Pinta Street				4b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 182-12-5781	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 20, 1924		9. Birthplace (State or Foreign Country) Ukraine			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Clinton							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 8607 Pinta Street				10f. Zip Code 20735			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944- If Yes, Give Year or Dates: 1966			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Air Force Ret.			16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Michael Stoyka				18. Mother's Name (First, Middle, Maiden Surname) Helen (Unknown)					
	19a. Informant's Name/Relationship (Type, Print) Sharon Carnal (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9106 Simpson Lane Clinton, Maryland 20735						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.			Feb 16, 2007	20c. Location - City or Town, State Cheltenham, Maryland		
	21. Signature of Funeral Service Licensee ► <i>M. O. D. B. 100153</i>			22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. Hypertension Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CNS Syphilis</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier ► <i>A. Rahimian MD</i>				29c. License number D0052999			29d. Date signed (Month, Day, Year) 2/12/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ali Rahimian MD, 7501 Surratts Clinton MD 20735</i>									
	31. Date filed (Month, Day, Year) FEB 12 2007			32. Registrar's Signature <i>Jeanne B. Frey</i>						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04009

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED SHAW				2. Date of Death Month Day Year 02/11/2007	3. Time of Death 3:40 AM		
	4a. Facility Name (If not institution, give street and number) Mariner Health of N. Arundel		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 215-30-8522		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 02/14/1932	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent		10a. State Md.		10b. County AA	10c. City, Town or Location Pasadena		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 110 Jackpine Drive			10f. Zip Code 21122			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1968-1970		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Samuel Gerbrick			18. Mother's Name (First, Middle, Maiden Surname) Rita Smith				
	19a. Informant's Name/Relationship (Type, Print) Frederick Shaw / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Jackpine Drive, Pasadena, MD 21122					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Meadowridge Mem Pk		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem Pk		Date 02/16/07	20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspirational pneumonia Approximate Interval Between Onset and Death few days							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Episodes of acute resp failure							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DM II, Hypertension, DVT rt. arm, presence ulcer on buttocks.							
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 313 HOSPITAL DR, GLEN BURNIE MD, 21041							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 							
	29c. License number D 029873							
	29d. Date signed (Month, Day, Year) 02/12/2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA KHANDELWAL, MD		32. Registrar's Signature 					
	31. Date filed (Month, Day, Year) FEB 12 2007							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04010

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Meredith SWIFT							2. Date of Death Month 2 Day 6 Year 2007	3. Time of Death 10:55 A M
	4a. Facility Name (If not institution, give street and number) HCR-MANOR CARE			4b. City, Town, or Location of Death TOWSON			4c. County of Death BALTO. CO.		
Funeral Director	5. Social Security Number 217-18-9192		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) JUNE 9, 1923	9. Birthplace (State or Foreign Country) M.D.	
	10a. State MD		10b. County BALTO.		10c. City, Town or Location ESSEX			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1040 N. MARLYN AVE				10f. Zip Code 21221			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: N/A			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN			16b. Kind of Business/Industry UNKNOWN		
17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN					
19a. Informant's Name/Relationship (Type, Print) Holloway J. SULLIVAN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. CALVERT ST. BALTO., MD 21202					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) GARRISON FOREST FEB 13, 2007				20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST FEB 13, 2007			Date FEB 13, 2007	20c. Location - City or Town, State BALTO. CO. MD	
21. Signature of Funeral Service Licensee Thomas J. Asadi Jr.				22. Name and Address of Facility SKARSHAF 2829 HUDSON ST. BALTO., MD 21224					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liver Cirrhosis									
Approximate Interval Between Onset and Death									
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown									
23d. Date of delivery Month 0 Day 0 Year 0000									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Cyrus Asadi, DO				29c. License number H0054424			29d. Date signed (Month, Day, Year) 2-8-07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 20 E Timonium Rd. Suite #209 Timonium, MD 21093									
31. Date filed (Month, Day, Year) FEB 12 2007				32. Registrar's Signature Laura B. Sparto					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04011

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death			
		WILLIAM H SCOTT		FEBRUARY 09 2007 0801 M					
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death					
UNIVERSITY OF MARYLAND MEDICAL CENTER		BALTIMORE		N/A					
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
213-62-4733		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	51 Yrs.			3-12-1955	Md.		
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location			
		Md.		NA		Baltimore			
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?					
836 W. Lombard Street		21201		USA					
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 10th grade		College (1-4or 5+)		Laborer		Joe's Construction			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
Lennie		Walker, Sr.		Gierta		Blunt			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Sharon Walker		Sister		5805 Clover Rd., Baltimore, Md. 21215					
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State				
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Mt. Carmel Cem.		2-15-07	Dundalk, Md.				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		March F.H. East					
► Gladys Warner		1101 E. North Avenue, Baltimore, Md. 21202							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): CIRRHOSIS		23c. Approximate Interval Between Onset and Death 2 months					
Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Due to (or as a consequence of): hepatitis c virus							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier ► Nadia Chaudhri		29c. License number 17403		29d. Date signed (Month, Day, Year) February 09, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
NADIA CHAUDHRI, 22 SOUTH GREENE STREET, BALTIMORE, MD 21201									
31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature Bevyn B. Appling							

07-01026

Franklin D. Sessions

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5 per MD G04 2/27/07

Certificate of Death

Reg. No.

2007 04012

1- For State
Registrar

1. Decedent's Name (First, Middle, Last)

Franklin D. Sessions Sr.

2. Date of Death

Month Day Year
February 6, 2007

3. Time of Death

1632 hrs

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any
injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1- For State
Registrar

1. Decedent's Name (First, Middle, Last)

Franklin D. Sessions Sr.

2. Date of Death

Month Day Year
February 6, 2007

3. Time of Death

1632 hrs

4a. Facility Name (if not institution, give street and number)

Howard County Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

214-02-4925
1925

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

24
Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

09-28-82

9. Birthplace (State or
Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

5423 Old Court Road

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married2 Married3 Widowed4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes2 No

If Yes, Give Year

or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No specify:

14. Race - American Indian, Black,

White, etc.

African-

Specify American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done

during most of working life. DO NOT use retired)

College (1-4 or 5+)

4

Fitness Trainer

16b. Kind of Business/Industry

Fitness Together

17. Father's Name (First, Middle, Last)

Donnell Sessions

18. Mother's Name (First, Middle, Maiden Surname)

Ave M. Strawder

19a. Informant's Name/Relationship (Type, Print)

Ave M. Strawder/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5609 Harpers Farm Rd., Columbia, Md 21044

20a. Method of Disposition

1 Burial2 Cremation3 Removal from State4 Donation5 Other Specify:

20b. Place of Disposition (Name of cemetery,

crematory or other place)

Date

20c. Location - City or Town, State

King Mem. Park

2/13/07

Woodlawn, Md

21. Signature of Funeral Service Licensee

Brenda M. DeLee

22. Name and Address of Facility

Mylie F/H P.A. of Balto.co.

9200 Liberty Rd., Randallstown, Md 21133

Physician
Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)

23d. Date of delivery

Month Day Year

9 Unknown9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient2 ER/Outpatient3 DOA4 Nursing Home5 Residence6 Other9 Unknown9 Unknown

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending Investigation6 Could not be determined

28a. Date of Injury (Month, Day, Year)

Feb 6, 2007

1545 hrs

1 Yes2 No

28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

Major Road / Highway

28d. Describe how injury occurred

Driver auto fixed object collision

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

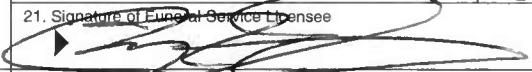
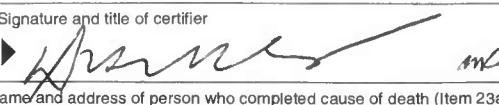
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04013

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sohan Somwara					2. Date of Death Month Day Year February 8, 2007	3. Time of Death 10:26 P M		
	4a. Facility Name (If not institution, give street and number) 824 North Woodlynn Road			4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 215-37-0627		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/22/1984	9. Birthplace (State or Foreign Country) South America			
	Usual Residence of Decedent Maryland Baltimore		10c. City, Town or Location Essex			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 824 North Woodlynn Road			10f. Zip Code 21221		10g. Citizen of What Country? South America			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: n/a		14. Race - American Indian, Black, White, etc. Specify: West Indian		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) n/a			16b. Kind of Business/Industry n/a			
	17. Father's Name (First, Middle, Last) Goorack Somwara				18. Mother's Name (First, Middle, Maiden Surname) Ahilia Harry				
	19a. Informant's Name/Relationship (Type, Print) Goorack Somwara (Father)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 North Woodlynn Road, Baltimore, Maryland 21221					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Bayview Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 02/14/2007	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. Respiratory Failure Due to (or as a consequence of): Muscular Dystrophy</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____		26. Place of Death Check only one 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) _____		28f. Location (Street and Number or Rural Route Number, City or Town, State) _____						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number D 16728		29d. Date signed (Month, Day, Year) 02/09/2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bo Zaw-Win, M.D., 6830 Hospital Drive, Baltimore, Maryland 21237								
State Registrar	31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one.

Medical Certification: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per dr., g868,067/15/07 dm
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04014

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Sheppard John Sheppard				2. Date of Death Month February Day 01 Year 2007	3. Time of Death 2055 M		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore		4b. City, Town, or Location of Death Baltimore City		4c. County of Death			
Funeral Director	5. Social Security Number unk	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	8. Date of Birth (Month, Day, Year) Aug 10, 1928	9. Birthplace (State or Foreign Country) North Carolina	
Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location Baltimore								
To Be Completed by Funeral Director	10e. Street and Number 3908 Ridgecroft Road				10f. Zip Code 21239	10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) unk		16b. Kind of Business/Industry disabled unk				
	17. Father's Name (First, Middle, Last) Samuel Grady/nephew				18. Mother's Name (First, Middle, Maiden Surname) unk			
	19a. Informant's Name/Relationship (Type, Print) Samuel Grady/nephew		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5803 Simmons Avenue Baltimore, MD 21215					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State unk		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
23a. Part I Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. Urinary Tract Infection Due to (or as a consequence of):</p> <p>b. Sepsis Due to (or as a consequence of):</p> <p>c. Dehydration Due to (or as a consequence of):</p> <p>d.</p>								
Approximate Interval Between Onset and Death								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred								
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Celia Valero MD								
29c. License number D63282								
29d. Date signed (Month, Day, Year) February 01, 2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Celia Valero MD Sinai Hospital of Baltimore								
31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature Jean B. Speller						

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patient Known as John Sheppard
Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2, should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

St. John, Jeanine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04015

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanine M. St. John					2. Date of Death Month Day Year February 4, 2007	3. Time of Death 4:00 PM M			
	4a. Facility Name (If not institution, give street and number) Holy Cross Nursing & Rehab			4b. City, Town, or Location of Death Burtonsville		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 329-32-5081	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct 18, 1938	9. Birthplace (State or Foreign Country) Illinois			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Burtonsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 3415 Greencastle Road			10f. Zip Code 20866		10g. Citizen of What Country? USA				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry licensed practical nurse healthcare					
	17. Father's Name (First, Middle, Last) Lorn Russell St. John				18. Mother's Name (First, Middle, Maiden Surname) Zelda Smith					
	19a. Informant's Name/Relationship (Type, Print) Renee Kidd/sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4304 Woodbury Street University Park, MD 20782						
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	<p>a. Cardiac arrhythmia Due to (or as a consequence of):</p> <p>b. Cardiomyopathy Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier [Signature]		29c. License number DOU 54566			29d. Date signed (Month, Day, Year) 2/5/07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunita Birogavilci 1220 A East Tampa Road, Suite 230, Towson, MD 21286									
	31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04016

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
OBAYEMI SOKOYA		02 02 2007		1200 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
HOLY CROSS HOSPITAL		SILVER SPRING		MONTGOMERY
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	8. Date of Birth (Month, Day, Year) 20 02 02 2007
NONE			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State	10b. County	10c. City, Town or Location MD PG COUNTY UPPER MARLBORO		
10e. Street and Number		10f. Zip Code 20774		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: BLACK	
14. Race - American Indian, Black, White, etc.		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) none College (1-4 or 5+) none		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none		16b. Kind of Business/Industry none		
17. Father's Name (First, Middle, Last) ABAYOMI M SOKOYA		18. Mother's Name (First, Middle, Maiden Surname) OMOSOLA OSUNFISAN		
19a. Informant's Name/Relationship (Type, Print) HOLY CROSS HOSPITAL		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 FOREST GLEN RD SILVER SPRING MD 20910		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 17.5 WKS GESTATION		
a. Due to (or as a consequence of): Estan Remoring				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0061442		
29b. Signature and title of certifier DR ERIC MARTIN ASHKIN		29d. Date signed (Month, Day, Year) 02/02/02		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR ERIC MARTIN ASHKIN 11119 ROCKVILLE PIKE ROCKVILLE MD 20852				
31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature Jesse B. Spauls		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 23a per dr.G864, 02/12/07 dbb Certificate of Death

Reg. No.

2007 04 017

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) ALFRED SIMMS 2. Date of Death Month January Day 27 Year 2007 3. Time of Death 4:24 A M									
Funeral Director		4. Facility Name (If not institution, give street and number) Maryland General Hospital 4b. City, Town, or Location of Death Baltimore City 4c. County of Death N/A									
To Be Completed by Funeral Director		5. Social Security Number 212-28-1391 6. Sex M 7. Age (In yrs. last birthday) 75 Yrs. 8. Date of Birth (Month, Day, Year) FEB. 15, 1931 9. Birthplace (State or Foreign Country) MARYLAND 10a. State MARYLAND 10b. County N/A 10c. City, Town or Location BALTIMORE CITY 10d. Inside City Limits Yes 10e. Usual Residence of Decedent 10f. Zip Code 21230 10g. Citizen of What Country? USA 10h. Street and Number 601 PACA STREET									
Physician /Medical Examiner		11. Marital Status Never Married 12. Was Decedent Ever in U.S. Armed Forces? No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) No 14. Race - American Indian, Black, White, etc. BLACK 15. Decedent's Education (Specify only highest grade completed) 8TH GRADE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER 16b. Kind of Business/Industry TRANSPORTATION 17. Father's Name (First, Middle, Last) THOMAS E. SIMMS SR 18. Mother's Name (First, Middle, Maiden Surname) CLARA 19a. Informant's Name/Relationship (Type, Print) MARGO JOHNSON (SISTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2036 CLIFFWOOD AVE., BALTIMORE MD 21213 20a. Method of Disposition Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY 01-31-07 Date 1 20c. Location - City or Town, State BALTIMORE MD 21. Signature of Funeral Service Licensee Jacqueline E. Roane 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Clostridium difficile colitis b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death									
Medical Certification: To Be Completed by Physician/Medical Examiner		23b. If Female: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown 23d. Date of delivery Month Day Year									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
Medical Certification: To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		26. Place of Death (Check only one) 28a. Date of Injury (Month, Day Year) MD 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		29b. Signature and title of certifier Mark Romig, M.D. MO 29c. License number 89536 29d. Date signed (Month, Day, Year) January 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Romig, M.D. / Maryland General Hospital 31. Date filed (Month, Day, Year) FEB 12 2007 32. Registrar's Signature John T. Spaulding									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04018

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick F. Schnitker					2. Date of Death Month Day Year February 8, 2007				3. Time of Death 5:27 p ^M
Funeral Director	4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore			
	5. Social Security Number 219-01-6134	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 1, 1918	9. Birthplace (State or Foreign Country) Maryland			

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	19. Informant's Name/Relationship (Type, Print) Helen E. Schnitker-wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19805 Valley Mill Rd., Freeland, MD 21053						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hilltop Serv Corp		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Serv Corp			Date 2/10/07	20c. Location - City or Town, State Towson, MD					
	21. Signature of Funeral Service Licensee William G. Dau					22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute stroke									Approximate Interval Between Onset and Death days		
	b. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
	c. Due to (or as a consequence of):											
	d. Due to (or as a consequence of):											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart failure, obstructive lung disease									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred						
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) February 8, 2007				
	29b. Signature and title of certifier W. A. Riley		29c. License number 025205									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley 6301 N. Charles St. Baltw. MD 21208											
State Registrar	31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature James B. Lester									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 019

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Golda M. Swires					2. Date of Death Month Day Year FEBRUARY 3, 2007	3. Time of Death 7:50 PM				
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 292-20-1411		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 7, 1922	9. Birthplace (State or Foreign Country) West Virginia			
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Timonium		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 12 Hollis Court			10f. Zip Code 21093			10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify:				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Charles Richards					18. Mother's Name (First, Middle, Maiden Surname) Laura Etta Arthur						
19a. Informant's Name/Relationship (Type. Print) Cheryl Lambert / daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Hollis Court; Timonium, MD 21093								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Peter U. Clancy			20b. Place of Disposition (Name of cemetery, crematory or other place) Greenlawn Cemetery			Date 2/8/07	20c. Location - City or Town, State Akron, Ohio				
21. Signature of Funeral Service Licensee Peter U. Clancy			22. Name and Address of Facility Ruck Towson Funeral Home			1050 York Road Towson, MD 21204					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death		
<p>a. RESPIRATORY ACIDOSIS Due to (or as a consequence of):</p> <p>b. RESPIRATORY FAILURE Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERICARDIAL EFFUSION DEMENTIA									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Boon Poh Lim, M.D.			29c. License number D 37254			29d. Date signed (Month, Day, Year) 2/5/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON POH LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204											
31. Date filed (Month, Day, Year) FEB 12 2007			32. Registrar's Signature James A. Jenkins								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

67

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 06 020

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James E. Shepherd</i>						2. Date of Death Month Day Year <i>February 6 2007</i>		3. Time of Death <i>1642 M</i>		
	4a. Facility Name (If not institution, give street and number) <i>R Adams Cowley Shock Trauma Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>Baltimore City</i>				
Funeral Director	5. Social Security Number <i>219-52-4350</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>58 Yrs.</i>		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) <i>10/30/1948</i>		9. Birthplace (State or Foreign Country) <i>VA</i>	
	Usual Residence of Decedent		10a. State <i>MD</i>		10b. County <i>HOWARD</i>		10c. City, Town or Location <i>COLUMBIA</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <i>9526 CABOOSE COURT</i>			10f. Zip Code <i>21045</i>			10g. Citizen of What Country? <i>USA</i>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>MARINE CORPS</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i></i>			14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>			
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+)</i> 5+ MECHANICAL ENGINEER ESTIMATOR			16b. Kind of Business/Industry <i>JOHN J. KIRLIN, IND.</i>				
	17. Father's Name (First, Middle, Last) <i>JAMES E. SHEPHERD</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>WANDA KAPEL</i>							
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>IRIS SHEPHERD / WIFE</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9526 CABOOSE COURT - COLUMBIA, MD 21045</i>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MD VETERANS CEMETERY</i>			Date <i>02/09/2007</i>	20c. Location - City or Town, State <i>OWINGS MILLS, MD</i>			
21. Signature of Funeral Service Licensee <i>Michael Dugger</i>			22. Name and Address of Facility <i>SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</i>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23c. Approximate Interval Between Onset and Death					
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p> <p>a. <i>Respiratory failure</i> Due to (or as a consequence of):</p> <p>b. <i>ARDS</i> Due to (or as a consequence of):</p> <p>c. <i>neutropenic pneumonia</i> Due to (or as a consequence of):</p> <p>d. _____</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier <i>Alex Flaxman MD</i>			29c. License number <i>P21040</i>			29d. Date signed (Month, Day, Year) <i>2/6/2007</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Alex Flaxman 225 Avenue St Baltimore, MD 21201</i>											
31. Date filed (Month, Day, Year) <i>FEB 12 2007</i>			32. Registrar's Signature <i>Leanne B. Appler</i>								

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04021

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosezena Thomas					2. Date of Death Month February Day 8, 2007 Year	3. Time of Death 9:30AM		
	4a. Facility Name (If not institution, give street and number) 6903 Friendship Road			4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 409 74 8625	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) May 9, 1950	9. Birthplace (State or Foreign Country) Tenn		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Clinton							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 6903 Friendship Road			10f. Zip Code 20735		10g. Citizen of What Country? United States			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: XX		14. Race - American Indian, Black, White, etc. <input checked="" type="checkbox"/> American Indian			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse Assistant		16b. Kind of Business/Industry Nursing				
	17. Father's Name (First, Middle, Last) Walter Thomas				18. Mother's Name (First, Middle, Maiden Surname) Marie				
	19a. Informant's Name/Relationship (Type, Print) Lillian Thomas (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6903 Friendship Road, Clinton, MD 20735					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Lee Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Date Feb 9, 2007	20c. Location - City or Town, State Clinton, MD		
	21. Signature of Funeral Service Licensee Douglas Frank m00257			22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer							Approximate Interval Between Onset and Death years	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {								
	a. Due to (or as a consequence of): Metastatic Colon Cancer	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9 Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier YUANNE NICOLE RUDDER		29c. License number DO060920			29d. Date signed (Month, Day, Year) 2/8/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUANNE NICOLE RUDDER, MD 9131 Piscataway Rd Clinton MD 20735								
State Registrar	31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature Leanne B. Aponte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rag. No.-

2007 04022

1- For
State
Registrar

Physician
/Medical
Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month 1 / Day 24 / Year 07	3. Time of Death 903 PM
Arbeautia Thompson				4b. City, Town, or Location of Death Baltimore			4c. County of Death Baltimore	
4a. Facility Name (If not institution, give street and number)		Manor Care Rossville		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Apr 14, 1928	9. Birthplace (State or Foreign Country) Virginia	
5. Social Security Number 219-30-3576		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.					
Usual Residence of Decedent								
10a. State MD	10b. County Baltimore	10c. City, Town or Location Glen Arm					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X	
10e. Street and Number 11639 Glen Arm Road				10f. Zip Code 21057			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 housewife			16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Moses Shores				18. Mother's Name (First, Middle, Maiden Surname) Maye Rose Lineberry				
19a. Informant's Name/Relationship (Type, Print) Alice Townsley/ great niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7835 Woodbine Road Airville, PA 17302				

20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
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21. Signature of Funeral Service Licensee Ronald S. Wade, Director	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
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23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <i>Progressive Disease</i> Due to (or as a consequence of):	
b. <i>Lung mass probable cancer</i> Due to (or as a consequence of):	
c. <i>Crash car accident with dysentery</i> Due to (or as a consequence of):	
d. <i>Sepsis</i>	

23b. If female: 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Fracture of thoracic bone going</i> <i>Chronic Pulmonary Disease</i>	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
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25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	--	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Ronald</i> MD	29c. License number D 31464	29d. Date signed (Month, Day, Year) 216/07
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAIB A. HASITMI MD, 821 N. EUTAW ST Suite 308, BALTIMORE MD 21201

31. Date filed (Month, Day, Year) FEB 12 2007	32. Registrar's Signature <i>Ronald S. Wade</i>
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Baltimore, Maryland 21215-0036

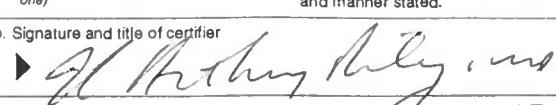
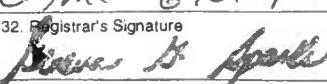
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
2007 04023

1- For State Registrar		Certificate of Death											
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death		
	George J. Thomas, Jr.							Month Day Year February 8, 2007			8:10 P M		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death				
	Glen Meadows				Glen Arm				Baltimore				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.			8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)				
206-20-9400		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	76 Yrs.	Months	Days	Hours	Min.	Nov. 23, 1930	Pennsylvania				
Usual Residence of Decedent													
10a. State	10b. County		10c. City, Town or Location							10d. Inside City Limits			
Maryland	Baltimore		Glen Arm							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?					
4518 Meadowcliff Road				21057				U.S.A.					
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.					
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1957-1982			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: White					
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry					
Elementary/Secondary (0-12)		College (1-4 or 5+)		Officer				U.S. Air Force					
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)									
George J. Thomas, Sr.				Regina M. Reilly									
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Stephanie McKew Daughter		4518 Meadowcliff Road Glen Arm, Maryland 21057											
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State					
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Hilltop Service Corp.				2-14-2007		Towson Maryland					
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death											
a. Aspiration pneumonia		days											
Due to (or as a consequence of):													
b. Dysphagia		weeks											
Due to (or as a consequence of):													
c. Dementia		year											
Due to (or as a consequence of):													
d.													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
				M									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 		29c. License number D25205				29d. Date signed (Month, Day, Year) February 9, 2007							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley 6701 N. Charles St. Baltimore MD 21208													
31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04024

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>LELAND WALKER</i>					2. Date of Death Month Day Year <i>FEBRUARY 9 2007</i>	3. Time of Death <i>✓ 2:51 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>NORTHWEST HOSPITAL CENTER</i>			4b. City, Town, or Location of Death <i>RANDALLSTOWN</i>	4c. County of Death <i>BALTIMORE</i>			
Funeral Director	5. Social Security Number <i>219-50-1128</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>57 Yrs.</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>07.17.1949</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>Baltimore</i>			10c. City, Town or Location <i>CATONSVILLE</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <i>2104 Fernglen WAY</i>			10f. Zip Code <i>21228</i>		10g. Citizen of What Country? <i>U.S.A</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1965</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>SPECIALIST</i>			16b. Kind of Business/Industry <i>Social Security</i>		
	17. Father's Name (First, Middle, Last) <i>Cornelius Walker</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Marion Scott</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Jane C Walker / Wife</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2104 Fernglen WAY, CATONSVILLE, MD 21228</i>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Arbutus</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus</i>		Date <i>02.15.2007</i>	20c. Location - City or Town, State <i>Baltimore, MD</i>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>			22. Name and Address of Facility <i>Vaughn C. Greene Funeral Service 8129 Liberty Road, Randallstown, MD 21133</i>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. Due to (or as a consequence of): <i>SEPTIC SHOCK</i></p> <p>b. Due to (or as a consequence of): <i>ASCENDING CHOLANGITIS</i></p> <p>c. Due to (or as a consequence of): <i>OBSTRUCTIVE JAUNDICE</i></p> <p>d. Due to (or as a consequence of): <i>GALL STONES</i></p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ACUTE MYOCARDIAL INFARCTION; NEURIBID OBESITY; RESPIRATORY FAILURE</i>							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) <i>M</i> 28b. Time of Injury <i>M</i> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>ORLANDO B. COVARRUBIAS MD</i> 29c. License number <i>D 19502</i> 29d. Date signed (Month, Day, Year) <i>FEBRUARY 9, 2007</i>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ORLANDO B. COVARRUBIAS</i> 31. Date filed (Month, Day, Year) <i>FEB 12 2007</i> 32. Registrar's Signature <i>Heidi H. Smith</i>							
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	33. Location (Street and Number or Rural Route Number, City or Town, State) <i>NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MARYLAND 21133</i>							

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04025

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORIS SISCO WEBER					2. Date of Death Month FEB. Day 9 Year 2007	3. Time of Death 1:40 PM	
	4a. Facility Name (If not institution, give street and number) THE DOVE HOUSE			4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL		
Funeral Director	5. Social Security Number 055 26 8324		6. Sex 1 ♂ M 2 ♀ F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) MAY 23 1930	9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent MD CARROLL		10a. State MD 10b. County CARROLL		10c. City, Town or Location ELDERSBURG		10d. Inside City Limits 1 Yes 2 No	
To Be Completed by Funeral Director	10e. Street and Number 1810 VINCENZA DRIVE UNITA			10f. Zip Code 21784		10g. Citizen of What Country? USA		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1960		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MICRO FILMER		16b. Kind of Business/Industry OCTO, INC.			
17. Father's Name (First, Middle, Last) WILLIAM SISCO				18. Mother's Name (First, Middle, Maiden Surname) MABEL VEALEY				
19a. Informant's Name/Relationship (Type, Print) THOMAS WEBER/HUSBAND					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 VINCENZA DRIVE UNITA ELDERSBURG MD 21784			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) SOUTH CARROLL CREM. 2/10/2007			Date WINFIELD, MD	20c. Location - City or Town, State JN ZUMBRUN FH & NOV CO 6028 SYKESVILLE RD ELDERSBURG MD 21784	
21. Signature of Funeral Service Licensee Jeffrey N. Zumburn					22. Name and Address of Facility Approximate Interval Between Onset and Death			
23a. Part I. For the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic CANCER-LIVER LESIONS								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {								
a. Due to (or as a consequence of): None								
b. Due to (or as a consequence of): None								
c. Due to (or as a consequence of): None								
d. Due to (or as a consequence of): None								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
					24a. Was an autopsy performed? 1 Yes 2 No			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No					26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide					28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred None	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) None			28f. Location (Street and Number or Rural Route Number, City or Town, State) None
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number D63031			29d. Date signed (Month, Day, Year) 2/9/2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. YOUSUF GAFFAR					31. Date filed (Month, Day, Year) FEB 12 2007			32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or use as the burial-transit

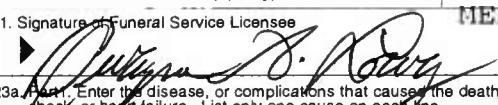
Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For Amend #5, 15, per FH, g600, 47907
State of Maryland Department of Health and Mental Hygiene
1- State Registrar Certificate of Death

2007 04026
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CALVIN MONROE YOUNG, JR.							2. Date of Death Month 2 Day 8 Year 07	3. Time of Death 1:50 PM
	4a. Facility Name (If not institution, give street and number) HCR-MANORCARE OF DULANEY				4b. City, Town, or Location of Death TOWSON			4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 3261 237-56-2361	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 03/29/1903	9. Birthplace (State or Foreign Country) S. CAROLINA		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE 10c. City, Town or Location TOWSON 10d. Inside City Limits 1 □ Yes 2 X No								
	10e. Street and Number 111 WEST ROAD				10f. Zip Code 21204			10g. Citizen of What Country? USA	
	11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give X Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MINISTER	16b. Kind of Business/Industry MINISTRY					
	17. Father's Name (First, Middle, Last) CALVIN M. YOUNG, SR.				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN				
	19a. Informant's Name/Relationship (Type, Print) CHRISTINE Y. GRAY/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3602 DELVESNE RD, BALTIMORE, MD 21218				
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BEATTIES FORD		Date 2/16/07	20c. Location - City or Town, State CHARLOTTE, NC			
	21. Signature of Funeral Service Licensee  MEMORIAL CARRIERS								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary artery disease								
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown								
	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown								
	24a. Was an autopsy performed? 1 □ Yes 2 X No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No								
	25. Was case referred to medical examiner? 1 □ Yes 2 X No								
	26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)								
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide								
	28a. Date of Injury (Month, Day Year)								
	28b. Time of Injury								
	28c. Injury at Work? M 1 □ Yes 2 □ No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number H0054424								
	29d. Date signed (Month, Day, Year) 2 - 10 - 07								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 20 E. Timonium Rd. Suite #209 Timonium, MD 21093								
	31. Date filed (Month, Day, Year) FEB 12 2007								
	32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 027

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Philip Young		2. Date of Death Month January Day 28 Year 2007		3. Time of Death 1059 PM
4a. Facility Name (If not institution, give street and number) Maryland General Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death
5. Social Security Number 283-44-5405		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 61 Yrs.	8. Date of Birth (Month, Day, Year) Oct 2, 1945
9. Usual Residence of Decedent 10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore
10e. Street and Number 501 W. Franklin Street		10f. Zip Code 21201		10g. Citizen of What Country? USA
11. Marital Status unk		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Year or Dates:	14. Race - American Indian, Black, White, etc. Specify: black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business/Industry unk
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		unk
19a. Informant's Name/Relationship (Type, Print) Maryland General Hospital		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 Linden Avenue Baltimore, MD 21201		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
21. Signature of Funeral Director Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		20c. Location - City or Town, State
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): Ventricular Fibrillation</p> <p>b. Due to (or as a consequence of): Atherosclerotic cardiovascular Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
<p>Approximate Interval Between Onset and Death minutes</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes mellitus Hypertension				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Jyoti Patel, MD		29c. License number D32158		29d. Date signed (Month, Day, Year) 1/29/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jyoti Patel, MD 821 N. Eutaw St., Ste 407, Baltimore, MD 21201				
31. Date filed (Month, Day, Year) FEB 12 2007		32. Registrar's Signature Marie B. Spaulding		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04028

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Elsie R. Ake</i>		01 28 2007		1148 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Coastal Hospice at the Lake</i>		<i>Salisbury</i>		<i>Wicomico</i>
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.
218-07-5303				
10a. State MD		10b. County Wicomico	10c. City, Town or Location Salisbury	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1109 South Schumaker Drive		10f. Zip Code 21804		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) none Manager	16b. Kind of Business/Industry Retail Sales	
17. Father's Name (First, Middle, Last) Fred Taylor		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Taylor		
19a. Informant's Name/Relationship (Type. Print) Linda Payne/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6057 Hunters Mill Drive, Salisbury, MD 21801		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Allen U.M. Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Allen U.M. Cemetery	Date 01/31/2007	20c. Location - City or Town, State Allen, Maryland
21. Signature of Funeral Service Licensee <i>Jones J. Turner</i> , MO0295		22. Name and Address of Facility Hinman Funeral Home	23. Approximate Interval Between Onset and Death 11673 Somerset Ave., Princess Anne, MD 21853	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>ALZHEIMER'S DISEASE</i>		
Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):		
{		b. Due to (or as a consequence of):		
{		c. Due to (or as a consequence of):		
{		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CEREBRO VASCULAR ARTERIO SCLEROSIS</i>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>James W. Braack</i>		29c. License number D14256		29d. Date signed (Month, Day, Year) 1/28/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>COASTAL HOSPICE AT THE LAKE</i> <i>THE LIGHTSHEATH HOSPITAL SALISBURY MD 21801</i>				
31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature <i>James W. Braack</i>		

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

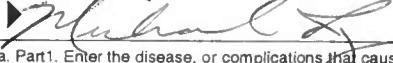
Certificate of Death

2007 04029

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
	JULIA MARY BUGIN				FEBRUARY 1, 2007 11:42P M	
Funeral Director	4a. Facility Name (If not institution, give street and number) 15150 HUGHESVILLE MANOR DRIVE				4b. City, Town, or Location of Death HUGHESVILLE	
	5. Social Security Number 232-34-5100	6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 24, 1925
Usual Residence of Decedent						
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location HUGHESVILLE		
10e. Street and Number 15150 HUGHESVILLE MANOR DRIVE				10f. Zip Code 20637		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME
17. Father's Name (First, Middle, Last) FRANK PLEVA, SR.				18. Mother's Name (First, Middle, Maiden Surname) AGNES GOLEMIEC		
19a. Informant's Name/Relationship (Type, Print) AGNES BUGIN-DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15150 HUGHESVILLE MANOR DR., HUGHESVILLE, MD		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MARY'S CHURCH CEM. 2-7-07		Date M00479 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646		
21. Signature of Funeral Service Licensee 						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Colon Cancer</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death						
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D28352				
29d. Date signed (Month, Day, Year) 2/21/07						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 1703 LaPlace LA 20646						
31. Date filed (Month, Day, Year) FEB 09 2007		32. Registrar's Signature 				

ORIGINAL

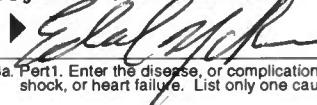
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 04030

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter Scott					2. Date of Death Month Day Year January 26, 2007			3. Time of Death 5:15 pm.
	4a Facility Name (If not institution, give street and number) 250 E. Main Street		4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil				
Funeral Director	5. Social Security Number 222-05-5176	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93	If Under 1 Year Yrs. Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) May 23, 1913	9. Birthplace (State or Foreign Country) Pennsylvania		
	10a. State Maryland		10b. County Cecil	10c. City, Town or Location Elkton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 250 E. Main Street		10f. Zip Code 21921			10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 19XX		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Contractor		16b. Kind of Business/Industry Excavating					
17. Father's Name (First, Middle, Last) George Barclay, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Jeanette Wilson							
19a. Informant's Name/Relationship (Type, Print) Elaine Barclay/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 E. Main Street Elkton, Maryland 21921							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Elaine Barclay		20b. Place of Disposition (Name of cemetery, crematory or other place) Lawncroft Crematory		Date 1/29/07	20c. Location - City or Town, State Linwood, Pennsylvania				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Strano & Feeley Family Funeral Home 635 Churchmans Road Newark, DE 19702							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) QVA							Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): Alzheimer's disease									
b. Due to (or as a consequence of): Alzheimer's disease									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Residence							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 223 West Main St Elkton, MD 21921					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number D04823		29d. Date signed (Month, Day, Year) 1/27/07					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JULIA H. HSU, MD									
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

341 VA
State Registrar

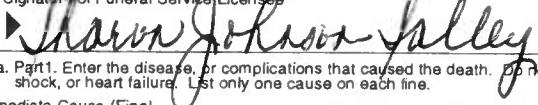
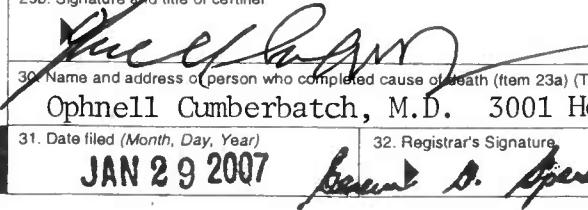
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 031

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES ARTHUR BURKE							2. Date of Death Month Day Year JANUARY 23, 2007			3. Time of Death 5:11 a.m.			
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY			4c. County of Death PRINCE GEORGE'S						
Funeral Director	5. Social Security Number 579-78-9731		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month Day Year) Dec. 2, 1958			9. Birthplace (State or Foreign Country) Wash., D.C.		
	10a. State D.C.		10b. County		10c. City, Town or Location Washington							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1317 T St., S.E.				10f. Zip Code 20020			10g. Citizen of What Country? United States						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Building Engineer			16b. Kind of Business/Industry D.C. Public Schools							
17. Father's Name (First, Middle, Last) Leonard T. Burke				18. Mother's Name (First, Middle, Maiden Surname) Ethel Blocker										
19a. Informant's Name/Relationship (Type, Print) Dwann Washington/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 T St., S.E. Wash., DC 20020										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery			Date 1-31-07		20c. Location - City or Town, State Washington, D.C.					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Washington, D.C. 20002										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)												Approximate Interval Between Onset and Death		
<p>a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):</p> <p>b. CORONARY ARTERY DISEASE Due to (or as a consequence of):</p> <p>c. CONGESTIVE HEART FAILURE Due to (or as a consequence of):</p> <p>d. END STAGE RENAL DISEASE</p>														
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D27577				29d. Date signed (Month, Day, Year) 1/24/07						
29b. Signature and title of certifier 				29c. Registrar's Signature 				29d. Date signed (Month, Day, Year) 1/24/07						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, M.D. 3001 Hospital Drive Cheverly, Md. 20785														
31. Date filed (Month, Day, Year) JAN 29 2007				32. Registrar's Signature										

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04032

1- For State Registrar		2. Date of Death Month Day Year Jan. 20, 2007										Reg. No.		
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Branch										3. Time of Death 2:30 a.m.			
	4a. Facility Name (If not institution, give street and number) Collingwood Nursing Home					4b. City, Town, or Location of Death Rockville					4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 579-56-9892		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days			8. Date of Birth (Month, Day, Year) Jan, 13, 1943	9. Birthplace (State or Foreign Country) Wash. D.C.				
To Be Completed by Funeral Director	10a. State MD		10b. County		10c. City, Town or Location Rockville					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 299 Hurley Ave.		10f. Zip Code 20850					10g. Citizen of What Country? U.S.A.						
Physician /Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1960-1964			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify:					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Private								
	17. Father's Name (First, Middle, Last) Harry Branch					18. Mother's Name (First, Middle, Maiden Surname) Grace Fitzgerald								
	19a. Informant's Name/Relationship (Type, Print) Rosa Branch-Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Brunswick Ave. #526 Silver Spring, MD 20910								
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cem. 2-12-07 Triangle, Va.			Data		20c. Location - City or Town, State Hunt Funeral Home 903 Kennedy St. N.W. Wash.D.C. 20011						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	Approximate Interval Between Onset and Death													
	Immediate Cause (Final disease or condition resulting in death) Urosepsis													
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
	a. Due to (or as a consequence of): Neurogenic Bladder													
	b. Due to (or as a consequence of): Cerebrovascular Accident													
	c. Due to (or as a consequence of):													
	d. _____													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9/Unknown					23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease													
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)													
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 20850													
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	29b. Signature and title of certifier A. Seidman MD					29c. License number D37801					29d. Date signed (Month, Day, Year) Jan. 24, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aimee Seidman, M.D. 15020 Shady Grove Road, Suite 300 Rockville, MD.													
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature A. Seidman											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04033

1- For State Registrar		2. Date of Death Month Day Year										Reg. No.	
Physician /Medical Examiner		January 27, 2007										3. Time of Death	
Funeral Director		4. Facility Name (If not institution, give street and number) Union Hospital of Cecil County Elkton										4c. County of Death Cecil	
		5. Social Security Number 217-26-8830		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month, Day, Year	9. Birthplace (State or Foreign Country) Maryland				
		March 8, 1930											
		Usual Residence of Decedent											
		10a. State Maryland	10b. County Cecil	10c. City, Town or Location North East								10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		10e. Street and Number 459 Red Toad Road		10f. Zip Code 21901								10g. Citizen of What Country? United States	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced X		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White				14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Food							
		17. Father's Name (First, Middle, Last) Joseph Frank Frock		18. Mother's Name (First, Middle, Maiden Surname) Cynthia Custus Traister									
		19a. Informant's Name/Relationship (Type, Print) Gina A. Karschner / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 459 Red Toad Road, North East, Maryland 21901									
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park		Date January 30, 2007	20c. Location - City or Town, State Elkton, Maryland						
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Crouch Funeral Home									
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
		Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): 1 day											
		b. COPD Due to (or as a consequence of): years											
		c. Due to (or as a consequence of):											
		d. Due to (or as a consequence of):											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
		23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier H Farkas, MD JAN 30 2007									
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		29c. License number D15314				29d. Date signed (Month, Day, Year) January 27, 2007			
		31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

4
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04034

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mable				2. Date of Death Month Day Year January 31, 2007 5:09 A M				3. Time of Death				
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince Georges				
Funeral Director	5. Social Security Number 218-30-2831	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2/06/1930	9. Birthplace (State or Foreign Country) Washington DC						
	Usual Residence of Decedent Maryland Charles				10c. City, Town or Location Brandywine				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10a. State Maryland				10b. County Charles				10e. Street and Number 15660 Ballards Place		10f. Zip Code 20613	10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker				16b. Kind of Business/Industry Domestic				
	17. Father's Name (First, Middle, Last) Raymond				18. Mother's Name (First, Middle, Maiden Surname) Proctor Pearle Proctor								
	19a. Informant's Name/Relationship (Type, Print) James Newman /Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15660 Ballards Pl. Brandywine, Maryland 20613								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Cremation</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Cremation		Date 2/9/07		20c. Location - City or Town, State Alex. Va Metropolitan Cremator						
	21. Signature of Funeral Service Licensee <i>Lloyd S. S.</i>				22. Name and Address of Facility Adams Funeral HomePA 191 20605 Aquasco Rd Aquasco, Maryland 20608								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTHEROSCLEROTIC CARDIOVASCULAR DISEASE												
	Approximate Interval Between Onset and Death												
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown												
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____												
	23d. Date of delivery Month Day Year												
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown												
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, HYPERTENSION CHRONIC OBSTRUCTIVE PULMONARY DISEASE RENAL FAILURE ANEMIA												
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide												
	28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No												
	28d. Describe how injury occurred												
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)												
	28f. Location (Street and Number or Rural Route Number, City or Town, State)												
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	29b. Signature and title of certifier <i>ATTENDING PHYSICIAN</i> 29c. License number D 52900												
	29d. Date signed (Month, Day, Year) 01-31-2007												
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUSA MOMO IT MD 8700 CENTRAL AV. #301, LANDOVER MD 20785												
	31. Date filed (Month, Day, Year) FEB 07 2007 32. Registrar's Signature <i>Reena K. Sood</i>												

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

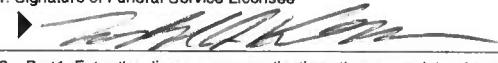
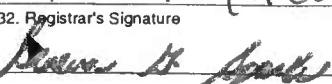
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 01 035
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Benlock							2. Date of Death Month Day Year January 19 2007 7:00 AM	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) Northwest Hospital			4b. City, Town, or Location of Death Randallstown			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 191 01 7757	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) April 21 1916	9. Birthplace (State or Foreign Country) PA			
Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Baltimore										
10e. Street and Number 4795 Byron Road				10f. Zip Code 21208			10g. Citizen of What Country? US			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Her Home			
17. Father's Name (First, Middle, Last) Walter Kurtz				18. Mother's Name (First, Middle, Maiden Surname) Theresa Rech						
19a. Informant's Name/Relationship (Type, Print) Phyllis Skovran daughter										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4795 Byron Road Baltimore MD 21208										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Nicholas Cemetery			Date Jan 22 2007	20c. Location - City or Town, State Brownsville PA				
21. Signature of Funeral Service Licensee 										
22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Rd., Winfield, MD 21784										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Clostridium difficile Colitis days										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Protein Malnutrition Dysphagia										
23d. Date of delivery Month Day Year										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number 62912			29d. Date signed (Month, Day, Year) January 19 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Kajubi 5401 Old Court Road Randallstown, Maryland										
31. Date filed (Month, Day, Year) JAN 26 2007		32. Registrar's Signature 								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04036

1- For
State
Registrar

Physician
/Medical
Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, *[Signature]*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Mark Lee Blackson		January 28, 2007				8:44p M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Union Hospital		Elkton				Cecil	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 22, 1938	9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent		10a. State MD 10b. County Cecil 10c. City, Town or Location Chesapeake City				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 860 Biddle St.		10f. Zip Code 21915				10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) -		16b. Decedent's Usual Occupation Driver		16b. Kind of Business/Industry Distributor	
17. Father's Name (First, Middle, Last) Charles T. Blackson				18. Mother's Name (First, Middle, Maiden Surname) Velma M. Reynolds			
19a. Informant's Name/Relationship (Type, Print) Patricia Blackson/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 860 Biddle St., Chesapeake City, MD 21915					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris Inc.		Date January 30, 2007	20c. Location - City or Town, State West Chester, PA		
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Andrew G. Gee Funeral Home 259 E. Main St., Elkton, MD 21921					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Hypoxia Due to (or as a consequence of):</p> <p>b. Chronic Pleural Effusion Due to (or as a consequence of):</p> <p>c. Lung Cancer Due to (or as a consequence of):</p> <p>d. Tobacco Abuse</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD Hypo thyrodisism							
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 056327		29d. Date signed (Month, Day, Year) 1/29/2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cydney T. Lee, MD 111 W. High St. Ste 312 Elkton, MD 21921							
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007-01-037

1- For State Registrar

**Physician/
Medical Examiner****Funeral
Director**

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036**Division of Vital Records, P.O. Box 68760,**Within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit**Medical Certification: To Be Completed by Physician/Medical Examiner****To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Year 2126 hrs	
William Joseph Clark		January 26, 2007			
4a. Facility Name (if not institution, give street and number) Union Hospital			4b. City, Town, or Location of Death Elkton		
5. Social Security Number 150-90-9942			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days Hours Min. Oct. 26, 1988
8. Usual Residence of Decedent Maryland			9. County of Death Cecil		
10a. State Maryland			10b. County Cecil		
10c. City, Town or Location Elkton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 36 Stoney Chase Drive			10f. Zip Code 21921		
10g. Citizen of What Country? United States					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify: White	
14. Race - American Indian, Black, White, etc.		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter	
16b. Kind of Business/Industry Housing					
17. Father's Name (First, Middle, Last) Frank C. Clark, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Holly Bruce		
19a. Informant's Name/Relationship (Type, Print) Frank C. Clark, Sr. / Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Stoney Chase Drive, Elkton, Maryland 21921		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:			20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist		Date February 3, 2007
			20c. Location - City or Town, State North East, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) of Head and Finger Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) Jan 26, 2007		28b. Time of Injury 2028 hrs	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Subject shot
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Apartment		28f. Location (Street and Number or Rural Route Number, City or Town, State) 311 Landing Lane Apt. 5, Elkton, Md.	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated			29d. Date signed (Month, Day, Year) January 27, 2007		
29b. Signature and title of certifier <i>[Signature]</i>			29c. License number O.C.M.E.		
30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201					
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

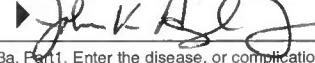
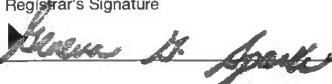
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04038

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Herbert Clevenger					2. Date of Death Month Day Year Jan 29, 2007	3. Time of Death 0253 M	
	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center					4b. City, Town, or Location of Death Westminster	4c. County of Death Carroll	
Funeral Director	5. Social Security Number 233-80-3394		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 26, 1950	9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent 10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 1202 Campus Ct.				10f. Zip Code 21157		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1969 1992		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2			16b. Kind of Business/Industry Social Security Administration	
	17. Father's Name (First, Middle, Last) Junior Lanier Clevenger				18. Mother's Name (First, Middle, Maiden Surname) Hazel Cowger			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Elfriede Clevenger wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Campus Ct. Westminster, MD 21157			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem		Date 2/5/07	20c. Location - City or Town, State Garrison, Maryland
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD				Approximate Interval Between Onset and Death minutes			
	23b. Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			
	23d. Date of delivery Month Day Year							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				28d. Describe how injury occurred			
	29b. Signature and title of certifier 				29c. License number 10051924		29d. Date signed (Month, Day, Year) January 30, 2007	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert D. Henderson 2973 Manchester Rd Manchester MD 21102				31. Date filed (Month, Day, Year) JAN 30 2007			
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL
15+1VA
x6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 039

1- For State Registrar

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last) Brenda Campbell				2. Date of Death Month Day Year January 31, 2007	3. Time of Death 0505 hrs
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9331
Funeral Director

4a. Facility Name (if not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery
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5. Social Security Number 579-80-3408	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 45	If Under 1 Year Yrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) March 8, 1961	9. Birthplace (State or Foreign Country) Washington D.C.
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10a. State Maryland		10b. County Montgomery	10c. City, Town or Location Silver Spring			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 4005 Postgate Terrace #102			10f. Zip Code 20906	10g. Citizen of What Country? United States		
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Black	14. Race - American Indian, Black, White, etc. Specify: Black
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk	16b. Kind of Business/Industry D.C. Government
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17. Father's Name (First, Middle, Last) Carnell Campbell			18. Mother's Name (First, Middle, Maiden Surname) Doris Huggins
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19a. Informant's Name/Relationship (Type, Print) Janet Campbell /Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Postgate Terrace #102 Silver Spring, Md. 20906
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Beth G. Lange 1/10/05</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) Gate Of Heaven	Date Feb.8, 2007	20c. Location - City or Town, State Silver Spring, Md.
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21. Signature of Funeral Service Licensee <i>Beth G. Lange 1/10/05</i>	22. Name and Address of Facility Alexander S. Pope, P.A. 5538 Marlboro Pike/Forestville, Md. 20747
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23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute coronary artery thrombosis Due to (or as a consequence of):			Approximate Interval Between Onset and Death
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b. Due to (or as a consequence of):			
--	--	--	--

c. Due to (or as a consequence of):			
--	--	--	--

d. Due to (or as a consequence of):			
--	--	--	--

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED #23a,27,perME, g864, 2/21/07 TT		
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other		
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc.			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
--	--	--	--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated				
---	--	--	--	--

29b. Signature and title of certifier <i>Zabiullah Ali</i>			29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 1, 2007
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30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	31. Date filed (Month, Day, Year) FEB 07 2007	32. Registrar's Signature <i>Alexander S. Pope</i>
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Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CR

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 007 04040

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Elsie Elizabeth Drew</i>						2. Date of Death Month Day Year Jan 24 2007	3. Time of Death 6:00 AM	
	4a. Facility Name (If not institution, give street and number) <i>St. Thomas More</i>			4b. City, Town, or Location of Death <i>Hyattsville</i>			4c. County of Death <i>Prince Georges</i>		
Funeral Director	5. Social Security Number <i>579 14 4908</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>96</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Nov 22 1910</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>		
To Be Completed by Funeral Director	10a. State <i>D.C.</i>						10b. County <i>Washington D.C.</i>		
	10c. City, Town or Location <i>Washington D.C.</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>1353 Michigan Ave NE</i>			10f. Zip Code <i>20017</i>			10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1946</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>			14. Race - American Indian, Black, White, etc.	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12 yrs.</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clerk</i>			16b. Kind of Business/Industry <i>H.E.W.</i>		
	17. Father's Name (First, Middle, Last) <i>William Joseph Miles</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary V. Washington</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Harold C. Drew / Son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1353 Michigan Ave NE Wash DC 20017</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Gate of Heaven</i>			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <i>1-30-2007</i>	20c. Location - City or Town, State <i>Silver Spring MD</i>		
	21. Signature of Funeral Service Licensee <i>Frank Shadell</i>			22. Name and Address of Facility <i>John T Rhines Funeral Home LLC 3015 14th ST NE Wash DC 20017</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Dementia</i>						Approximate Interval Between Onset and Death <i>years</i>		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) <i>Unknown</i>		
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Stage IV social dementia</i>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Paul A. Devore MD</i>			29c. License number <i>DO185-2</i>			29d. Date signed (Month, Day, Year) <i>24 JANUARY 2007</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul A. Devore MD 4203 Greenbaum Rd Hyattsville MD 20781</i>								
State Registrar	31. Date filed (Month, Day, Year) <i>JAN 29 2007</i>			32. Registrar's Signature <i>Patricia A. Apert</i>					

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

1- For State Registrar	Physician /Medical Examiner	
To Be Completed by Physician/Medical Examiner		
Medical Certification: To Be Completed by Physician/Medical Examiner		
<p>To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.</p> <p>Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</p>		
<p>CF (5)</p> <p>State Registrar</p>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04041

Reg. No.

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jayesh N. Dharia					2. Date of Death Month Day Year Jan. 26, 2007	3. Time of Death 5:10a m
	4a. Facility Name (If not institution, give street and number) 20224 Harbor Tree Road			4b. City, Town, or Location of Death E. Montgomery Village		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 620-48-7166	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year 5/09/1958	9. Birthplace (State or Foreign Country) India
Usual Residence of Decedent							
10a. State MD		10b. County Montgomery		10c. City, Town or Location E. Montgomery Village			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 20224 Harbor Tree Road				10f. Zip Code 20886		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: Asian			14. Race - American Indian, Black, White, etc. Specify: Specify: Asian
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Engineer			Texas Instruments
17. Father's Name (First, Middle, Last) Navnitlal Dharia				18. Mother's Name (First, Middle, Maiden Surname) Hansa Kadakia			
19a. Informant's Name/Relationship (Type, Print) Harshal Dharia/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20224 Harbor Tree Road E. Montgomery Village Maryland 20886			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Crem.				20b. Place of Disposition (Name of cemetery, crematory or other place) 1/27/2007		Date 1/27/2007	20c. Location - City or town, State Beltsville, Md.
21. Signature of Funeral Service Licensee 							
22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md 20910							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer							
Approximate Interval Between Onset and Death 18 mo.							
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 							
29c. License number D41715							
29d. Date signed (Month, Day, Year) Jan. 26, 2007							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Venkatraman MD 6201 Greenbelt Rd #U-3 College Park, Md 20246							
31. Date filed (Month, Day, Year) JAN 29 2007							
32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

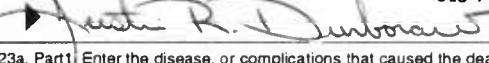
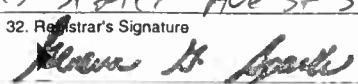
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 042

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Vernon Denk							2. Date of Death Month Day Year January 23, 2007	3. Time of Death 8:35 p M	
	4a. Facility Name (If not institution, give street and number) Continuum Care at Sykesville			4b. City, Town, or Location of Death Sykesville			4c. County of Death Carroll			
Funeral Director	5. Social Security Number 217-18-3154	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) May 20, 1923	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Carroll 10c. City, Town or Location Westminster								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 102 Timber Ridge Drive #102				10f. Zip Code 21157			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Plate Marker			16b. Kind of Business/Industry Printing			
	17. Father's Name (First, Middle, Last) Harry Denk				18. Mother's Name (First, Middle, Maiden Surname) Isabel Morrissey					
	19a. Informant's Name/Relationship (Type, Print) Margaret D. Denk, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Timber Ridge Dr #102, Westminster, MD 21157					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) South Carroll Crematory			Date 01/25/2007	20c. Location - City or Town, State Winfield, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Years	
	<p>a. Dementia Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 					
					29c. License number DO058137			29d. Date signed (Month, Day, Year) 1/24/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilbur Kus 295 Stover Ave ST 307 Westminster MD 21157									
State Registrar	31. Date filed (Month, Day, Year) JAN 25 2007		32. Registrar's Signature 							

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended #30 State of Maryland / Department of Health and Mental Hygiene		2007 04043	
1. For State Registrar per JW 1/29/07		Certificate of Death	
Physician /Medical Examiner		Reg. No.	
1. Decedent's Name (First, Middle, Last) <i>Judith A. Dailey</i>		2. Date of Death Month Day Year <i>Jan. 24 2007</i>	
4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER		3. Time of Death 3. Time of Death Month Day Year <i>2101 M</i>	
5. Social Security Number 166-36-3757		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	
7. Age (In yrs. last birthday) 62 Yrs.		8. If Under 1 Year Months Days Hours Min. 9. Birthplace (State or Foreign Country) FEBRUARY 23, 1944 FLORIDA	
Usual Residence of Decedent MARYLAND QUEEN ANNE'S		10c. City, Town or Location CHESTER	
10e. Street and Number 513 TEAL COURT		10f. Zip Code 21619	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: WHITE	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INTERIOR DESIGNER		16b. Kind of Business/Industry DEPARTMENT OF HOUSING URBAN DEVELOPMENT	
17. Father's Name (First, Middle, Last) JAMES DAILEY		18. Mother's Name (First, Middle, Maiden Surname) KATHARINE KELLEY	
19a. Informant's Name/Relationship (Type, Print) FRANCESCA RYAN/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 KENTBURY WAY, BETHESDA, MARYLAND 20814	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>CHESAPEAKE CREMATION</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION	
21. Signature of Funeral Service Licensee <i>Carl M. H. Dailey</i>		22. Name and Address of Facility FELLOWS, HELFENBEIN, AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>Acute Myocardial Infarction</i> <i>immediate</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last		<i>Coronary Artery Disease</i> <i>5 years</i>	
a. Due to (or as a consequence of): <i>Dilated Cardiomyopathy</i> <i>5+ years</i>			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Type 2 Diabetes Mellitus</i>			
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier <i>MICHEAL EMMER</i>		29c. License number D005120	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEMOCRACY 6316 DEMOCRACY BLVD, BETHESDA, MARYLAND 20817		29d. Date signed (Month, Day, Year) <i>January 25 2007</i>	
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature <i>James H. Dailey</i>	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

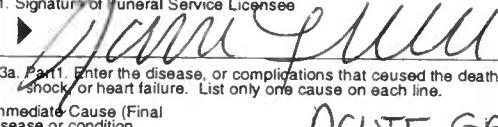
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04044

For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death				3. Time of Death			
	Kenneth E. Ellsworth Jr.				Month	Day	Year	1002 M				
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death			
	Memorial Hospital				Cumberland				Allegany			
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.			8. Date of Birth		9. Birthplace (State or Foreign Country)	
	214-88-3855		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	47 Yrs.	Months	Days	Hours	Min.	Month Day Year	Nov 6, 1959	MD	
Usual Residence of Decedent		10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits				
		WV	Mineral	Fort Ashby				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number						10f. Zip Code		10g. Citizen of What Country?				
213 Bowden Drive						26719		USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: white				
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry							
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 4			Self-Employed			Investor				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)										
Kenneth E. Ellsworth, Sr.		Shirley (Eversole) Ellsworth										
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		19c. Date		19d. Location - City or Town, State						
Pamela Ellsworth wife		213 Bowden Drive Fort Ashby WV 26719		2/6/2007		LaVale MD						
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Date		20d. Location - City or Town, State						
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Restlawn Memorial Gardens		2/6/2007		LaVale MD						
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.		23b. Approximate Interval Between Onset and Death						
		Scarpelli Funeral Home, P.A.		108 Virginia Avenue, Cumberland, MD 21502		1 DAY						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.		23b. Approximate Interval Between Onset and Death										
Immediate Cause (Final disease or condition resulting in death)		a. ACUTE GASTROINTESTINAL HEMORRHAGE Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):										
{		c. Due to (or as a consequence of):										
d. _____												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify) _____		23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE HYPERTENSION HYPERLIPIDEMIA ALCOHOLISM		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number		29d. Date signed (Month, Day, Year)								
29b. Signature and title of certifier 		D0059987		2-7-2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
Christopher Vagnoni		902 Seton Drive Suite 203 Cumberland MD 21502										
31. Date filed (Month, Day, Year)		32. Registrar's Signature										
FEB 09 2007												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04045

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernadette Lucille Forbes							2. Date of Death Month Day Year February 6, 2007	3. Time of Death 9:50A M	
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care			4b. City, Town, or Location of Death La Plata			4c. County of Death Charles			
Funeral Director	5. Social Security Number 589-23-6507		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 14, 1919	9. Birthplace (State or Foreign Country) Haiti		
	10a. State MD		10b. County Charles		10c. City, Town or Location La Plata			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1026 Llano Drive				10f. Zip Code 20646			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 8			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Haitian			14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Sewing			
17. Father's Name (First, Middle, Last) Numais Vital					18. Mother's Name (First, Middle, Maiden Surname) Imeldea Luc					
19a. Informant's Name/Relationship (Type, Print) Claire Fenelus/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1026 Llano Drive, La Plata, MD 20646					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Paul C. Schulz		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery			Date 2/9/2007	20c. Location - City or Town, State La Plata, Maryland				
21. Signature of Funeral Service Licensee M00945		22. Name and Address of Facility Arehart-Echols Funeral Home, P.A.			23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic.					
23a. Immediate Cause (Final disease or condition resulting in death)		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of): Metastatic Pancreatic cancer			Approximate Interval Between Onset and Death		
23d. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23e. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ► Atul K. Katyal, MD		29c. License number D0061652			29d. Date signed (Month, Day, Year) 2/7/2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATUL KATYAL, SUITE #304, 11350 Penbrooke Dr., Woodlawn, MD 20607		31. Date filed (Month, Day, Year) FEB 09 2007			32. Registrar's Signature James B. Jacobs					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04046

amend item 1 - For State Registrar #5, perfh, bg, 2/1/07

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Geraldine R. Fisher							2. Date of Death Month Day Year 01 30 2007	3. Time of Death 16:30 PM
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 235-60-7546		6. Sex 1 □ M 2 X F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months 01	If Under 24 Hrs. Days 30	8. Date of Birth (Month, Day, Year) 12-16-1938	9. Birthplace (State or Foreign Country) West Virginia	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Somerset 10c. City, Town or Location Princess Anne								
	10e. Street and Number 31431 Peggy Neck Road			10f. Zip Code 21853			10g. Citizen of What Country? USA		
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: None		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: None			14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Granvil R. Mills				18. Mother's Name (First, Middle, Maiden Surname) Maude Amber Mills				
	19a. Informant's Name/Relationship (Type, Print) Robert Fisher/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31431 Peggy Neck Road, Princess Anne, MD 21853					
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) None			20b. Place of Disposition (Name of cemetery, crematory or other place) Allen U.M. Cemetery		Date 02/04/2007	20c. Location - City or Town, State Allen, Maryland		
	21. Signature of Funeral Service Licensee Jones & Fisher Jr.			22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia Stroke								
	Approximate Interval Between Onset and Death 1 D. 1 D. 1 D.								
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Father had long Disease Congestive Heart Failure								
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown								
	24a. Was an autopsy performed? 1 □ Yes 2 X No			24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
	25. Was case referred to medical examiner? 1 □ Yes 2 X No			26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) None		28f. Location (Street and Number or Rural Route Number, City or Town, State) None			
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D005479					
	29b. Signature and title of Certifier Gregory Treuth, MD			29d. Date signed (Month, Day, Year) 1/30/2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory Treuth, MD 100 E. Carroll St. Salisbury MD 21801								
	31. Date filed (Month, Day, Year) FEB 01 2007			32. Registrar's Signature Beau A. Jones					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

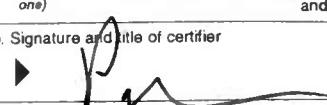
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04047

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VLADIMIR GLEYZERMAN							2. Date of Death Month Day Year JANUARY 25, 2007	3. Time of Death 9:00 A M			
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL			4b. City, Town, or Location of Death BETHESDA			4c. County of Death MONTGOMERY					
Funeral Director	5. Social Security Number 220-33-1931	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months 08	If Under 24 Hrs. Days 09	8. Date of Birth (Month, Day, Year) 08/09/1919	9. Birthplace (State or Foreign Country) UKRAINE					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MARYLAND									10b. County MONTGOMERY	10c. City, Town or Location ROCKVILLE	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 6121 MONTROSE ROAD			10f. Zip Code 20852			10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12)		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: College (1-4 or 5+)			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAWYER			16b. Kind of Business/Industry LAW					
	17. Father's Name (First, Middle, Last) SABSAY GLEYZERMAN					18. Mother's Name (First, Middle, Maiden Surname) CLARA KRATSBUCH						
	19a. Informant's Name/Relationship (Type, Print) TSETILIA BAYTINA/ EX WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12630 VIERS MILL ROAD #418, ROCKVILLE, MARYLAND 20853								
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESSED SHEL EMMES			Date 01/28/2007	20c. Location - City or Town, State WASHINGTON, D.C.				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis									Approximate Interval Between Onset and Death 1 day		
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Urinary Tract Infection									Approximate Interval Between Onset and Death 1 day		
	c. d.											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input checked="" type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)						23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA						Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier 		29c. License number D56652						29d. Date signed (Month, Day, Year) January 25, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Poffenroth, MD 1201 Seven Locks Road #200 Rockville, MD 20854											
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature 									

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04048

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MOI GIANG							2. Date of Death Month Day Year JAN 25 2007	3. Time of Death 11:40 AM
	4a. Facility Name (If not institution, give street and number) Lorien Nursing & Rehab. Center				4b. City, Town, or Location of Death Columbia			4c. County of Death Howard	
Funeral Director	5. Social Security Number 217-06-6891	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 3, 1933	9. Birthplace (State or Foreign Country) Vietnam		
Usual Residence of Decedent									
	10a. State Maryland	10b. County Howard	10c. City, Town or Location Laurel					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9687 Halstead Avenue				10f. Zip Code 20723			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1968-1970			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Asian			14. Race - American Indian, Black, White, etc. Specify: Asian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Dang Giang					18. Mother's Name (First, Middle, Maiden Surname) Mung Thi Nguyen				
19e. Informant's Name/Relationship (Type, Print) Mai Nguyen Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8139 Clifford Court, Laurel, Maryland 20723					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metropolitan Crematory				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date Jan. 27, 2007	20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee Anhien J. Cole				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Approximate Interval Between Onset and Death									
Immediate Cause (Final disease or condition resulting in death) a. SEPSIS 2° to STAPHYLOCOCCUS AUREUS days Due to (or as a consequence of):									
b. END STAGE RENAL DISEASE months Due to (or as a consequence of):									
c. FAILURE TO THRIVE months Due to (or as a consequence of):									
d. _____									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Shawn Maia Gupta MD					29c. License number DO 053150			29d. Date signed (Month, Day, Year) JANUARY 26 2007	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SHAWN MAIA GUPTA 9650 SANTIAGO RD SUITE 110 MD COLUMBIA 21045									
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature Shawn Maia Gupta							

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

State Registrar

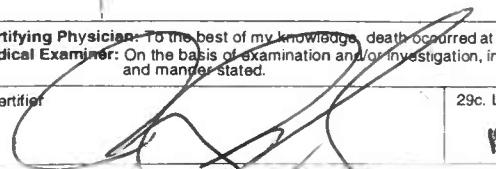
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04049

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Grimm Gluck							2. Date of Death Month Jan Day 25 Year 2007	3. Time of Death 2:45 PM								
	4a. Facility Name (If not institution, give street and number) Carroll Hospice Dove House				4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll									
Funeral Director	5. Social Security Number 173-03-2098	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb 13 1916	9. Birthplace (State or Foreign Country) PA										
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Westminster 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
	10e. Street and Number 425 Pleasanton Road				10f. Zip Code 21157		10g. Citizen of What Country? USA										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor/Machinist			16b. Kind of Business/Industry Koppers Co.										
	17. Father's Name (First, Middle, Last) Clarence Gluck				18. Mother's Name (First, Middle, Maiden Surname) Nancy Bowers												
	19a. Informant's Name/Relationship (Type, Print) Tillie Gluck/wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 Pleasanton Rd Westminster, MD 21157											
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc			20c. Location - City or Town, State Hampstead, MD											
	21. Signature of Funeral Service Licensee 																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																
Physician /Medical Examiner	<table border="1"> <tr> <td>a. Sepsis - Cerebral Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 3 days</td> </tr> <tr> <td>b. Dysphagia Due to (or as a consequence of):</td> <td>2nd</td> </tr> <tr> <td>c. Aspiration Pneumonia Due to (or as a consequence of):</td> <td>2nd</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									a. Sepsis - Cerebral Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 days	b. Dysphagia Due to (or as a consequence of):	2nd	c. Aspiration Pneumonia Due to (or as a consequence of):	2nd	d.	
a. Sepsis - Cerebral Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 days																
b. Dysphagia Due to (or as a consequence of):	2nd																
c. Aspiration Pneumonia Due to (or as a consequence of):	2nd																
d.																	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																
	<table border="1"> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
	<table border="1"> <tr> <td>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA</td> <td>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice</td> </tr> </table>									Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice						
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice																
	26. Place of Death (Check only one) <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other																
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide																
	<table border="1"> <tr> <td>28a. Date of Injury (Month, Day, Year)</td> <td>28b. Time of Injury</td> <td>28c. Injury at Work?</td> <td>28d. Describe how injury occurred</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Hospice</td> </tr> </table>									28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred			<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospice
28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred														
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospice														
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home																
	28f. Location (Street and Number or Rural Route Number, City or Town, State) Westminster, MD																
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
	29b. Signature and title of certifier 																
	29c. License number 13744a																
	29d. Date signed (Month, Day, Year) 1-26-07																
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander Bowers Gluck 425 Pleasanton Road Westminster, MD																
	31. Date filed (Month, Day, Year) JAN 26 2007																
	32. Registrar's Signature 																

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

WSL X

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

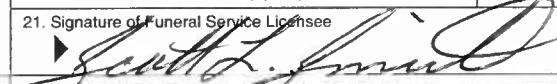
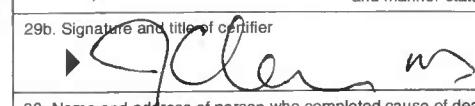
Amended

For
State
Registrar item #17, per F. Home, 2/6/07, B.A.

Certificate of Death WCHD

Reg. No.

2007 04 050

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Richard C. Greulich								2. Date of Death Month Jan. Day 27 Year 2007	3. Time of Death 6:55P^M		
Funeral Director		4a. Facility Name (If not institution, give street and number) 79 Watertown Rd.								4b. City, Town, or Location of Death Ocean Pines	4c. County of Death Worcester		
To Be Completed by Funeral Director		5. Social Security Number 291 20 0046	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) March 22, 1928	9. Birthplace (State or Foreign Country) Colorado					
		Usual Residence of Decedent 10a. State MD 10b. County Worcester 10c. City, Town or Location Ocean Pines								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 79 Watertown Rd.				10f. Zip Code 21811			10g. Citizen of What Country? USA				
Physician /Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Scientific Administrator							
		17. Father's Name (First, Middle, Last) William Walter Greulich William Warner Greulich				18. Mother's Name (First, Middle, Maiden Surname) Mildred Libby							
		19a. Informant's Name/Relationship (Type, Print) Bertha Greulich (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 79 Watertown Rd., Ocean Pines, Md. 21811							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Cape Henlopen Crem.		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 2-2-2007		20c. Location - City or Town, State Frankford, DE					
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811									
		23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multi System Organ Failure								Approximate Interval Between Onset and Death			
		b. Due to (or as a consequence of): Prostate / Bladder Cancer											
		c. Due to (or as a consequence of): COPD											
		d.											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____									
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		29b. Signature and title of certifier 		29c. License number D0058701 (md)				29d. Date signed (Month, Day, Year) 1/30/07					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Acm md		31. Date filed (Month, Day, Year) JAN 30 2007				32. Registrar's Signature 					

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend #5 Per FH G864 2/28/07 JA
State Registrar

Certificate of Death

Reg. No.

2007 04051

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

DHMH 17 Rev 1/2001

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) HELEN MAE HARTMAN				2. Date of Death Month February Day 2 Year 2007	3. Time of Death 1115 AM		
Funeral Director		4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL		4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON			
		5. Social Security Number 6538 234-44-3568	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month Day Year) 5/24/1926	9. Birthplace (State or Foreign Country) WEST VIRGINIA	
		Usual Residence of Decedent 10a. State WV 10b. County BERKELEY		10c. City, Town or Location BUNKER HILL				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		10e. Street and Number 372 HENSHAW ROAD			10f. Zip Code 25413		10g. Citizen of What Country? USA		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) CUSTODIAN		16b. Kind of Business/Industry BERKELEY COUNTY BOARD OF EDUCATION			
		17. Father's Name (First, Middle, Last) JOHN EDWARD WALTERS			18. Mother's Name (First, Middle, Maiden Surname) EDNA SHIPE				
		19a. Informant's Name/Relationship (Type. Print) KATHY FLETCHER/DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 372 HENSHAW ROAD, BUNKER HILL, WV 25413				
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PLEASANT VIEW MEMORY GARDENS		Date FEBRUARY 6, 2007	20c. Location - City or Town, State MARTINSBURG, WV		
		21. Signature of Funeral Service Licensee Chelsom Brown		22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atrial Fibrillation Due to (or as a consequence of): Approximate Interval Between Onset and Death							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month 0 Day 0 Year 0			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State) Hagerstown, MD 21740	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) 215107	
		29b. Signature and title of certifier Jane Marie						29c. License number D060396	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID MURSHED						31. Date filed (Month, Day, Year) FEB 09 2007	
		32. Registrar's Signature Jane B. Justice						ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04052

1- For
State
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donovan Gene Hammond, Sr.							2. Date of Death Month Day Year February 2, 2007	3. Time of Death 22:08PM		
	4a. Facility Name (If not institution, give street and number) 8947 Light St.			4b. City, Town, or Location of Death Williamsport			4c. County of Death Washington				
Funeral Director	5. Social Security Number 214-42-1045		6. Sex M	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) March 15 1943	9. Birthplace (State or Foreign Country) Maryland			
	10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport			10d. Inside City Limits Yes			
To Be Completed by Funeral Director	10e. Street and Number 8947 Light St.			10f. Zip Code 21795			10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)				16b. Kind of Business/Industry Union Representative			
17. Father's Name (First, Middle, Last) Richard Irvin Hammond					18. Mother's Name (First, Middle, Maiden Surname) Oneda Louise Palmer						
19a. Informant's Name/Relationship (Type, Print) Sharon L. Hammond / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8947 Light St Williamsport Maryland 21795							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) R. R.			20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery			Date 2/06/07	20c. Location - City or Town, State Hagerstown, Maryland				
21. Signature of Funeral Service Licensee R. R.				22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Brain Astrocytoma Due to (or as a consequence of): 14 years											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c. d.											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home	28f. Location (Street and Number or Rural Route Number, City or Town, State) Hagerstown, MD 21740	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29c. License number D46473	29d. Date signed (Month, Day, Year) Feb 5, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hind Hammond MD 1130 OPAL CT., Hagerstown, MD 21740									31. Date filed (Month, Day, Year) FEB 09 2007	32. Registrar's Signature Judie	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

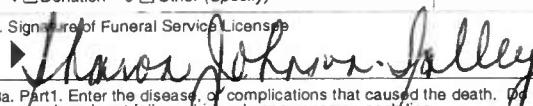
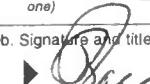
State of Maryland / Department of Health and Mental Hygiene

2007 04053

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARRIE HOLLIS							2. Date of Death Month JANUARY Day 20 Year 2007	3. Time of Death 1:30 PM		
	4a. Facility Name (If not institution, give street and number) FOXCHASE REHAB & NURSING CENTER			4b. City, Town, or Location of Death SILVER SPRING			4c. County of Death MONTGOMERY				
Funeral Director	5. Social Security Number 430-40-3157	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 7-12-1925	9. Birthplace (State or Foreign Country) ARKANSAS				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County MONTGOMERY 10c. City, Town or Location SILVER SPRING 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number 2015 EAST -WEST HIGHWAY			10f. Zip Code 20910			10g. Citizen of What Country? UNITED STATES				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: X			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK			14. Race - American Indian, Black, White, etc. Specify:			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COUNSELOR			16b. Kind of Business/Industry GOVERNMENT				
	17. Father's Name (First, Middle, Last) CYPRUS G. HOLLIS				18. Mother's Name (First, Middle, Maiden Surname) L' CLAIRETTE HUGHES						
	19a. Informant's Name/Relationship (Type, Print) FRANK HOLLIS/BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 742 COLUMBIA RD. NW WASHINGTON, D.C. 20001						
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORIUM			Date 1/26/07	20c. Location - City or Town, State BELTSVILLE, MD		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE. WASH, DC 20002						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S DEMENTIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 2 YEARS		
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STROKE HYPERTENSION								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier 			
								29c. License number D28656		29d. Date signed (Month, Day, Year) January 25, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RAVI PASSI 8609 2nd Ave., #404 B Silver Spring Md. 20910										
	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at all times.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04054

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Perdita J. Hansberry							2. Date of Death Month Day Year Jan. 24, 2007	3. Time of Death 3:24 a M
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-70-4243	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Dec. 12, 1951	9. Birthplace (State or Foreign Country) Wash.D.C.
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Prince Georges 10c. City, Town or Location Hyattsville								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1015 Consideration Lane			10f. Zip Code 20785			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1951			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Manager		16b. Kind of Business/Industry AT & T				
	17. Father's Name (First, Middle, Last) Coy Jones				18. Mother's Name (First, Middle, Maiden Surname) Juanita Powell				
	19a. Informant's Name/Relationship (Type, Print) Donald J. Hansberry Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 1015 Consideration La. Hyattsville, MD. 20785						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Harmony Mem. Park		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park			Date Feb. 1, 07	20c. Location - City or Town, State Landover, MD		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Francois B. Hunt			22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St. N.W. Wash.D.C. 20011					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PANCREATIC CANCER								Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): PANCREATIC CANCER								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State) Silver Spring, MD. 20910			
	29b. Signature and title of Certifier Kanwaljit K. Nagi, M.D.		29c. License number 064491			29d. Date signed (Month, Day, Year) 1/24/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanwaljit K. Nagi, M.D. 1500 Forest Glen Rd. Silver Spring, MD. 20910		31. Date filed (Month, Day, Year) JAN 29 2007			32. Registrar's Signature James D. Perez			

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CR (5)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

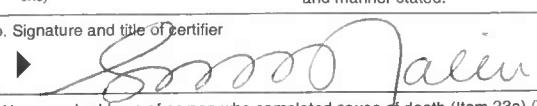
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04055

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CRISTINE DELOIS HICKS					2. Date of Death Month Day Year JANUARY 24, 2007	3. Time of Death 5:15 PM									
	4a. Facility Name (If not institution, give street and number) 14833 SILVERSTONE DRIVE			4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY										
Funeral Director	5. Social Security Number 577-36-8897	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 87	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JANUARY 10, 1920	9. Birthplace (State or Foreign Country) ALABAMA									
	Usual Residence of Decedent 10a. State MARYLAND			10b. County MONTGOMERY			10c. City, Town or Location SILVER SPRING		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Funeral Director	10e. Street and Number 14833 SILVERSTONE DRIVE			10f. Zip Code 20905		10g. Citizen of What Country? U.S.A.										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3		16b. Decedent's Usual Occupation ACCOUNTANT		16b. Kind of Business/Industry GENERAL ACCOUNTING OFFICE									
	17. Father's Name (First, Middle, Last) WINFIELD GOODIN				18. Mother's Name (First, Middle, Maiden Surname) LILLIE REYNOLDS											
	19a. Informant's Name/Relationship (Type, Print) PAMELA P. JOHNSON - NIECE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14833 SILVERSTONE DRIVE, SILVER SPRING, MARYLAND 20905												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHELTENHAM MARYLAND STATE VETERANS CEMETERY		Date 1/29/2007	20c. Location - City or Town, State CHELTENHAM, MARYLAND									
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
	<table border="0"> <tr> <td>a. LUNG CANCER Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>								a. LUNG CANCER Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
a. LUNG CANCER Due to (or as a consequence of):	Approximate Interval Between Onset and Death															
b. Due to (or as a consequence of):																
c. Due to (or as a consequence of):																
d. Due to (or as a consequence of):																
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred									
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)															
	28f. Location (Street and Number or Rural Route Number, City or Town, State)															
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
	29b. Signature and title of Certifier 				29c. License number MD22075		29d. Date signed (Month, Day, Year) JANUARY 25, 2007									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAKUNTALA MALIK, M.D., 3800 RESERVOIR DR., NW, WASHINGTON, D.C. 20007															
	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature 													

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04056

Reg. No.

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stephanie Caroline Hurley					2. Date of Death Month Jan. Day 22, Year 2007	3. Time of Death 1630 M	
	4a. Facility Name (If not institution, give street and number) 1177 Glenwood Dale Drive			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 026-03-9691	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) Aug 28, 1906	9. Birthplace (State or Foreign Country) Westport MA.	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MA. 10b. County Bristol 10c. City, Town or Location Fall River						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 230 Globe Street			10f. Zip Code 02724		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Textile		
	17. Father's Name (First, Middle, Last) Michael Pogubila				18. Mother's Name (First, Middle, Maiden Surname) Anna Albrecht			
	19a. Informant's Name/Relationship (Type, Print) Priscilla McDermott Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1177 Glenwood Dale Drive Annapolis, MD 21409		Date Jan 29 2007		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Blessed Virgin Mary			20b. Place of Disposition (Name of Cemetery, crematory or other place)		20c. Location - City or Town, State Fall River MA.		
	21. Signature of Funeral Service Licensee Patt J. H.M.			22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Annapolis MD 21401				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA Approximate Interval/Between Onset and Death 1m year							
	23b. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) IF FEMALE: 23c. Was decedent pregnant in the past 12months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Far advanced Dementia							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Death Home							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 10 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Michael J. Lentz 29c. License number D 21438 29d. Date signed (Month, Day, Year) January 23, 2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL J. LENTZ 445 DEFENSE HIGHWAY ANNAPOLIS MD 21401							
State Registrar	31. Date filed (Month, Day, Year) JAN 26 2007			32. Registrar's Signature Patt J. H.M.				

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04057

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Waunita Lagrita Hoover							2. Date of Death Month Day Year January 24 2007	3. Time of Death 9:36 AM	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 220-42-0288		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 8, 1927	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent MD		10a. State Montgomery		10b. County Germantown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 17404 Onax Dr.			10f. Zip Code 20874			10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own home					
	17. Father's Name (First, Middle, Last) Shumaker				18. Mother's Name (First, Middle, Maiden Surname) unknown					
	19a. Informant's Name/Relationship (Type, Print) Jesse L. Hoover - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17404 Onax Dr., Germantown, MD 20874					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Rest Haven Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 1/29/2007	20c. Location - City or Town, State Hagerstown, MD			
	21. Signature of Funeral Service Licensee Waunita Lagrita Hoover				22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd., Libertytown, MD 21762					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia								Approximate Interval Between Onset and Death Days	
	a. Due to (or as a consequence of): Pneumonia								Days	
	b. Due to (or as a consequence of):								Days	
	c. Due to (or as a consequence of):								Days	
	d. Due to (or as a consequence of):								Days	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown				23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	Diabetes Mellitus								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) January 24, 2007		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) Rockville, MD 20850					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D64444						29d. Date signed (Month, Day, Year) Jan 24, 2007	
	29b. Signature and title of certifier Arijit Dasgupta									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dasgupta Arijit, 9901 Medical Center Dr., Rockville, MD 20850									
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature James B. Sparta							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

W 51
6

Within 24 hours after death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04058

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

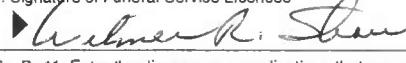
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantly: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death			
Herman L. Jenkins, Jr.		January 23, 2007				5:15 A. M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
Future Care Pineview Nursing Home		Clinton				Prince George's			
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 11, 1936	9. Birthplace (State or Foreign Country) Maryland		
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Suitland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2103 Porter Avenue		10f. Zip Code 20746				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry City Contractor					
17. Father's Name (First, Middle, Last) Herman L. Jenkins, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Hazel Hall							
19a. Informant's Name/Relationship (Type, Print) Ms. Hazel M. Jenkins (Mother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Porter Avenue Suitland, Maryland 20746							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date January 31, 2007		20c. Location - City or Town, State Clinton, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death							
<p>a. Due to (or as a consequence of): Cancer Of Esophagus</p> <p>b. Due to (or as a consequence of): Liver Metastasis</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier 		29c. License number D-24535				29d. Date signed (Month, Day, Year) January 27, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa, M.D.		31. Date filed (Month, Day, Year) JAN 29 2007						32. Registrar's Signature 	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of DeathReg. No. *2007-01-059*1. For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0620 hrs
Robert Francis Jording, Jr	February 1, 2007	

**Funeral
Director**

4a. Facility Name (if not institution, give street and number) 354 North Colonial Avenue	4b. City, Town, or Location of Death Westminster	4c. County of Death Carroll	
5. Social Security Number 214-98-1812	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY) Sept 24, 1968	9. Birthplace (State or Foreign Country) MD

To Be Completed by Funeral Director

10a. State MD	10b. County Carroll	10c. City, Town or Location Westminster	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 354 North Colonial Avenue		10f. Zip Code 21157	10g. Citizen of What Country? USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. White Specify:
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Laborer	16b. Kind of Business/Industry Stambaugh Paving Co
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17. Father's Name (First, Middle, Last) Robert F. Jording, Sr	18. Mother's Name (First, Middle, Maiden Surname) Betty Branham
---	---

19a. Informant's Name/Relationship (Type, Print) Melissa Ann Jording/wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1269 Guadelupe Drv Westminster, MD 21157
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>R. J. Jording</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc	Date 2/06/2007	20c. Location - City or Town, State Hampstead, MD
--	---	-----------------------	---

21. Signature of Funeral Service Licensee <i>R. J. Jording</i>	22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A.
---	---

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
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Immediate Cause (Final disease or condition resulting in death) a. Hypertensive cardiovascular disease Due to (or as a consequence of):	
--	--

b. _____ Due to (or as a consequence of):	
--	--

c. _____ Due to (or as a consequence of):	
--	--

d. _____	
----------	--

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	#23a,27,perME, g865, 3/2/07 TT
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Theodore M. King, Jr., MD</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 1, 2007
---	---	--	--

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD, Assistant Medical Examiner	31. Date filed (Month, Day, Year) FEB 06 2007	32. Registrar's Signature <i>Robert Francis Jording</i>
--	---	--

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical ExaminerWJSL
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Amended Items 23b & 26 per Physician 01/30/2007 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 060

For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathleen Irene Jones				2. Date of Death Month Jan Day 27 Year 2007	3. Time of Death 8:26 M	
	4a. Facility Name (If not institution, give street and number) 1935 Running Brooke Drive		4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 220-28-3754	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan 23 1933	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Manchester				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 3045 Westminster Street				10f. Zip Code 21102	10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1960-1964		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Oval Track Promotions		
	17. Father's Name (First, Middle, Last) William J.F. Stewart				18. Mother's Name (First, Middle, Maiden Surname) Bertha Elizabeth Myers		
	19a. Informant's Name/Relationship (Type, Print) Rick Jones/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1955 Running Brooke Dr Westminster, MD 21158		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Rick Jones		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's UCC Cem		Date 01/31/2007	20c. Location - City or Town, State Silver Run, MD	
	21. Signature of Funeral Service Licensee R. S. P. Jones				22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 412 Washington Rd Westminster, MD 21157		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic LipoSarcoma				Approximate Interval Between Onset and Death 17R		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last D. T. II. H TN CAD. Coronary artery disease						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Hypertension CAD. Coronary artery disease				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Son's		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D16206		29d. Date signed (Month, Day, Year) 1/29/2007		
	29b. Signature and title of certifier E. PALLAN, R.D.		32. Registrar's Signature Blanca B. Garcia				
	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04061

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert L. Kline				2. Date of Death Month January Day 26 , Year 2007	3. Time of Death 7:55A. M		
	4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Center		4b. City, Town, or Location of Death Baltimore		4c. County of Death			
Funeral Director	5. Social Security Number 170-18-0827	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 4, 1916	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent				10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Beltsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 3215 Dunnington Road			10f. Zip Code 20705		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Bus Operator		16b. Kind of Business/Industry Metro			
	17. Father's Name (First, Middle, Last) James Walter			18. Mother's Name (First, Middle, Maiden Surname) Kline			Tesza Leona	Williams
19a. Informant's Name/Relationship (Type, Print) James B. Kline -son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13011 Elkridge Street Beltsville, Maryland 20705			Date	20c. Location - City or Town, State George Washington Cemetery 1/29/2007 Adelphi, Maryland	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Approximate Interval Between Onset and Death years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
a. Complications of dementia Due to (or as a consequence of):								
b. _____ Due to (or as a consequence of):								
c. _____ Due to (or as a consequence of):								
d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number D58303			29d. Date signed (Month, Day, Year) January 26 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Charles 6701 N. Charles St Baltimore MD 21204								
31. Date filed (Month, Day, Year) JAN 29 2007			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04062

1- For State Register		2. Date of Death Month Day Year January 27, 2007								3. Time of Death M
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francine Marie Kaval								4c. County of Death Charles	
Funeral Director	4a. Facility Name (If not institution, give street and number) Genesis Elder Care Center				4b. City, Town, or Location of Death La Plata					
To Be Completed by Funeral Director	5. Social Security Number 220-62-9960		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 12, 1953	9. Birthplace (State or Foreign Country) Ohio		
	Usual Residence of Decedent 10a. State Maryland 10b. County Charles 10c. City, Town or Location Waldorf								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 11210A Heron Place				10f. Zip Code 20603				10g. Citizen of What Country? US	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 4			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-Or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Para-legal				16b. Kind of Business/Industry Legal	
	17. Father's Name (First, Middle, Last) William G. Kaval, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Frances Hackendorf				
	19a. Informant's Name/Relationship (Type, Print) Frances M. Kaval - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100012 Timberwood Ct., Upper Marlboro, MD 20772					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Crematory			Date 1-29-2007	20c. Location - City or Town, State Waldorf, MD			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility M01391 3035 Old Washington Road Huntt Funeral Home Waldorf, MD 20601							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiorespiratory Arrest								Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Metastatic Lung Cancer									
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disseminated Intravascular Coagulation								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) ATUL KATYAL MD, PH 301-830-2285					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0061652						29d. Date signed (Month, Day, Year) 1/27/07	
	29b. Signature and title of certifier 									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite A 304, 11350 Pembroke Sq, BURDORF MD ATUL KATYAL MD, PH 301-830-2285									
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 2a or 2b-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04063

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Carroll Kelbaugh							2. Date of Death Month 1	Day 26	Year 2007	3. Time of Death A.M. 2:30
	4a. Facility Name (If not institution, give street and number) 17526 Prettyboy Dam Road							4b. City, Town, or Location of Death Parkton			4c. County of Death Baltimore
Funeral Director	5. Social Security Number 215-50-0916	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 6/14/1958	9. Birthplace (State or Foreign Country) York, PA				
	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Parkton							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 17526 Prettyboy Dam Road				10f. Zip Code 21120			10g. Citizen of What Country? United States			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1968 - 1970		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Auto Detailer						
	17. Father's Name (First, Middle, Last) Carroll Edward Kelbaugh				18. Mother's Name (First, Middle, Maiden Surname) Adela M. Fair						
	19a. Informant's Name/Relationship (Type, Print) Carroll Edward Kelbaugh - Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17717 Prettyboy Dam Road, Parkton, MD 21120						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mt. Carmel Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery		Date 1/29/2007	20c. Location - City or Town, State Parkton, Maryland					
	21. Signature of Funeral Service Licensee Steven W. Eline M00723				22. Name and Address of Facility Eline funeral Home, 934 South Main Street, Hampstead, Maryland 21074						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atrial Fibrillation Due to (or as a consequence of): d. _____										
	Approximate Interval Between Onset and Death										
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown										
	23d. Date of delivery Month Day Year										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obesity Angina										
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide										
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred										
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier Josue C. Laredo										
	29c. License number D0008242										
	29d. Date signed (Month, Day, Year) January 26, 2007										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Josue C. Laredo, MD 4041 Gill Ave., Hampstead, MD 21074										
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature Josue C. Laredo								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

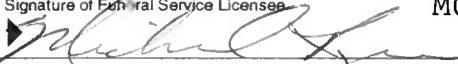
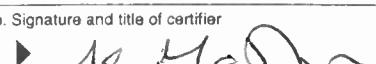
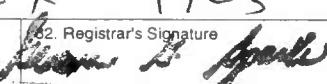
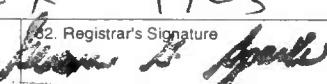
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04064
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOLORES ANN LEWIS							2. Date of Death Month Day Year FEBRUARY 1, 2007	3. Time of Death 2:00PM			
	4a. Facility Name (If not institution, give street and number) 13010 BRITTS BROOK LANE			4b. City, Town, or Location of Death WALDORF			4c. County of Death CHARLES					
Funeral Director	5. Social Security Number 236-56-1287	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) JAN. 20, 1937	9. Birthplace (State or Foreign Country) WEST VIRGINIA					
	10a. State MARYLAND			10b. County CHARLES			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 13010 BRITTS BROOK LANE			10f. Zip Code 20601			10g. Citizen of What Country? U.S.A.						
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: XX			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME					
17. Father's Name (First, Middle, Last) WILLIS COOMBS					18. Mother's Name (First, Middle, Maiden Surname) RUBY DUNCAN							
19a. Informant's Name/Relationship (Type, Print) HOMER A. LEWIS, JR. - HUSBAND					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13010 BRITTS BROOK LANE, WALDORF, MD 20601							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) TRINITY MEMORIAL GDNS. 2-6-07 WALDORF, MARYLAND					20b. Place of Disposition (Name of cemetery, crematory or other place) M00479			Date	20c. Location - City or Town, State RAYMOND FUNERAL SERVICE, P.A.			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility LA PLATA, MARYLAND 20646							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death							
<p>a. CARDIAC END Stage Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home					28f. Location (Street and Number or Rural Route Number, City or Town, State) La Plata, MD 20646							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number 028352					29d. Date signed (Month, Day, Year) 2/2/07		
29b. Signature and title of certifier 					29c. License number 028352					29d. Date signed (Month, Day, Year) 2/2/07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 1703 La Plata MD 20646					32. Registrar's Signature 							
31. Date filed Month, Day, Year FEB 09 2007					32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Es

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

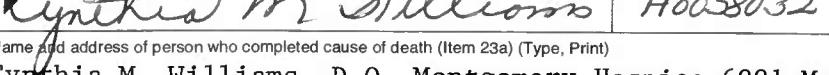
State of Maryland / Department of Health and Mental Hygiene

State of Maryland
1- For State Registrar AMEND#29dperMD2/7/07, BMW, MoCo

Certificate of Death

Beg. No.

04.065

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Morris Levin						2. Date of Death Month January Day 25 , Year 2007	3. Time of Death 11:00 PM			
	4a. Facility Name (If not institution, give street and number) The Casey House - Montgomery Hospice			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 138-03-4033	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth Month 2 Day 25 Year 1913	9. Birthplace (State or Foreign Country) PA				
							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Montgomery		10c. City, Town or Location Silver Spring								
	10e. Street and Number 3100 North Leisure World Blvd #212			10f. Zip Code 20906			10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Owner			16b. Kind of Business/Industry Grocery				
	17. Father's Name (First, Middle, Last) Harry Levin				18. Mother's Name (First, Middle, Maiden Surname) Yetta Karnovsky						
	19a. Informant's Name/Relationship (Type. Print) Sherry Kamber - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14430 Sugarland Lane Poolesville MD 20837							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) King David Mem Gardens			20b. Place of Disposition (Name of cemetery, crematory or other place) King David Mem Gardens			Date 1/28/07	20c. Location - City or Town, State Falls Church, VA			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Multiple Myeloma Due to (or as a consequence of): d. Approximate Interval Between Onset and Death										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier  Cynthia M. Williams		29c. License number HOA58032	29d. Date signed (Month, Day, Year) January 26, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O. Montgomery Hospice 6001 Muncaster Mill Road Rockville MD										20855	
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature 									
State Registrar											

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04066

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: Item 27 is marked other than "natural"; or item 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last)		Lawson				2. Date of Death Month Day Year January 24, 2007	3. Time of Death 12:55 P.M.
Arlie W. Lawson							
4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George's	
5. Social Security Number 228-05-5464		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept. 8, 1913	9. Birthplace (State or Foreign Country) Virginia
Usual Residence of Decedent		10c. City, Town or Location Beltsville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State Maryland		10b. County Prince George's					
10e. Street and Number 4405 Sellman Road		10f. Zip Code 20705				10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Transportation			
17. Father's Name (First, Middle, Last) Clarence		18. Mother's Name (First, Middle, Maiden Surname) Lawson Lula Fletcher					
19a. Informant's Name/Relationship (Type, Print) Myrtle Lawson -wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 Sellman Road Beltsville, Maryland 20705					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery		Date	20c. Location - City or Town, State 1/29/2007 Adelphi, Maryland		
21. Signature of Funeral Service Licensee Donald V. Borgwardt		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. Hypoxemic Respiratory Failure Due to (or as a consequence of):							
b. Ventricular Tachycardia Due to (or as a consequence of):							
c. Pneumonia Due to (or as a consequence of):							
d. Congestive Heart Failure							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Myrtle Vancha				29c. License number D0064760		29d. Date signed (Month, Day, Year) January 24, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mythily Vancha, M.D. 10724 Little Patuxent Parkway Columbia, Maryland 21044							
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature Barbara A. Jones					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04067

1. For State
RegistrarPhysician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1227 hrs
Ross Michael Littrell	February 4, 2007	

Funeral
Director

4a. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	4c. County of Death Prince George's Montgomery			
5. Social Security Number 220-76-2776	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	8. If Under 1 Year Months Days Hours Min.	9. Date of Birth (MM/DD/YYYY) July 30, 1960	10. Birthplace (State or Foreign Country) Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent		10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 12415 Denley Road			10f. Zip Code 20902		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Mason	
17. Father's Name (First, Middle, Last) Robert M. Littrell			18. Mother's Name (First, Middle, Maiden Surname) Benigna C. Caballero		

19a. Informant's Name/Relationship (Type, Print)
Benigna C. Littrell/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18301 Georgia Avenue, Apt. 310, Olney, Maryland 20832

20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other Specify
Metropolitan Crematory

20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
February 6, 2007

20c. Location - City or Town, State
Alexandria, Virginia

21. Signature of Funeral Service Licensee

Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive cardiovascular disease Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. _____		
<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED #4C, 23a, 27, per ME, g864, 2/21/07 TT	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
_____	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
_____	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:

27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 7 Homicide
4 Homicide

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work?
1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc.
(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only one)
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

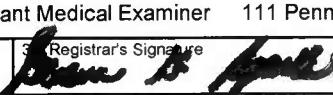
29b. Signature and title of certifier


29c. License number
O.C.M.E.

29d. Date signed (Month, Day, Year)
February 5, 2007

30. Name and address of person who completed cause of death (Item 23a)
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)
FEB 07 2007

32. Registrar's Signature


ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04068
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sylvia Lucille Lucchese						2. Date of Death Month January Day 26 Year 2007	3. Time of Death 1:35A M	
	4a. Facility Name (If not institution, give street and number) Glade Valley Nursing & Rehab Center			4b. City, Town, or Location of Death Walkersville			4c. County of Death Frederick		
Funeral Director	5. Social Security Number 053-01-5693	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 5, 1915	9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent 10a. State MD 10b. County Frederick 10c. City, Town or Location Walkersville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 56 W. Frederick St.			10f. Zip Code 21793			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: claims adjustor	14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hartzler Funeral Home			16b. Kind of Business/Industry insurance co.		
	17. Father's Name (First, Middle, Last) unknown			18. Mother's Name (First, Middle, Maiden Surname) Angelena Ruggiero					
	19a. Informant's Name/Relationship (Type, Print) Mary Jane McDermott - daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Oyster Place, Rockledge FL 32955					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Jonica L. Brothers			20b. Place of Disposition (Name of cemetery, crematory or other place) A11 County Cremation			Date 1/27/2007	20c. Location - City or Town, State Sykesville, MD	
	21. Signature of Funeral Service Licensee Jonica L. Brothers			22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular Accident Approximate Interval Between Onset and Death Days								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease								
Medical Certification: To Be Completed by Physician/Medical Examiner	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home								28f. Location (Street and Number or Rural Route Number, City or Town, State) 801 Toll House Ave, Federicksburg, VA 22501
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier S. Saeed Tariq Khan								29c. License number D43091
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saeed Tariq Khan								29d. Date signed (Month, Day, Year) 1-26-07
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007			32. Registrar's Signature S. Saeed Tariq Khan					

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be consulted at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be consulted at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 069
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel V. Michael							2. Date of Death Month Day Year February 3 2007	3. Time of Death 1:00 PM	
	4a. Facility Name (If not institution, give street and number) REEDERS MEMORIAL HOME				4b. City, Town, or Location of Death BOONSBORO			4c. County of Death WASHINGTON		
Funeral Director	5. Social Security Number 234-01-9467	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 12/22/1911	9. Birthplace (State or Foreign Country) WEST VIRGINIA			
	Usual Residence of Decedent 10a. State WV		10b. County BERKELEY	10c. City, Town or Location MARTINSBURG				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 300 SILVER LANE APT. 307				10f. Zip Code 25401			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR			16b. Kind of Business/Industry NATIONAL FRUIT (APPLE PACKING)		
	17. Father's Name (First, Middle, Last) BERKELEY M. GANO				18. Mother's Name (First, Middle, Maiden Surname) MARY J. FISHELL					
	19a. Informant's Name/Relationship (Type, Print) ROSALEE G. ETTINGER/NIECE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 S. ALABAMA AVENUE, MARTINSBURG, WV 25401					
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT				20b. Place of Disposition (Name of cemetery, crematory or other place) PEASANT VIEW MEMORY GARDENS		Date FEBRUARY 6, 2007	20c. Location - City or Town, State MARTINSBURG, WV		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Charles M. Brown				22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA								Approximate Interval Between Onset and Death 2 weeks	
	b. Due to (or as a consequence of): CONGESTIVE HEART FAILURE								YEARS	
	c. Due to (or as a consequence of): DEMENITIA								YEARS	
	d. Due to (or as a consequence of): SEVERE ARTHRITIS								YEARS	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	29b. Signature and title of certifier H. Deale MD		29c. License number D 46561				29d. Date signed (Month, Day, Year) Feb, 03, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ghazala Qadir 20311 Lapans Rd. Boonsboro, MD 21713 301-432-8470									
	31. Date filed (Month, Day, Year) FEB 09 2007		32. Registrar's Signature Gwen B. Spangler							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

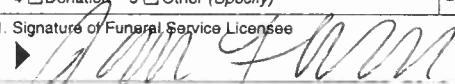
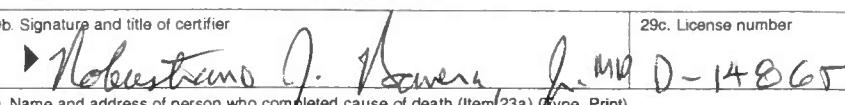
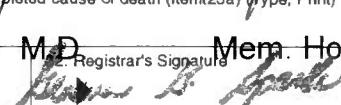
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04070

Reg. No.

1- For State Registrar		2. Date of Death Month Day Year Feb 5, 2007										3. Time of Death M 0130						
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theresa E. Millar										4a. Facility Name (If not institution, give street and number) Allegany County Nursing Home		4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany	
	5. Social Security Number 220-10-8807		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months		If Under 24 Hrs. Hours		8. Date of Birth (Month, Day, Year) Feb 22, 1919		9. Birthplace (State or Foreign Country) WV					
Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Cumberland										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Funeral Director	10e. Street and Number 612 Woodlawn Terrace					10f. Zip Code 21502					10g. Citizen of What Country? USA							
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer				16b. Kind of Business/Industry American Can Co.									
	17. Father's Name (First, Middle, Last) Harry C. Mills					18. Mother's Name (First, Middle, Maiden Surname) Elizabeth K. Mills												
	19a. Informant's Name/Relationship (Type, Print) Teresa Wilson friend					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 N. Mechanic St. Cumberland MD 21502												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Sunset Memorial Park				20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park				20c. Date 2/7/2007 Location - City or Town, State Cumberland MD									
	21. Signature of Funeral Service Licensee 										22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue, Cumberland, MD 21502							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT										Approximate Interval Between Onset and Death 5 yrs							
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																	
Physician /Medical Examiner	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown										23d. Date of delivery Month Day Year							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
											24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
	29b. Signature and title of certifier 										29c. License number D-14865							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										29d. Date signed (Month, Day, Year) FEB 5TH, 2007							
	31. Date filed (Month, Day, Year) FEB 09 2007										32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event. Item 27 must be marked "natural" if there was no injury or trauma.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04071
Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

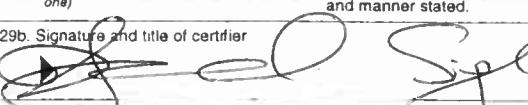
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
LONNIE MASON, JR.		01 23 2007				8:11 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
WASHINGTON ADVENTIST HOSPITAL		TAKOMA PARK				MONTGOMERY	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 01-20-1926	9. Birthplace (State or Foreign Country) SANFORD, NC
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MD	10b. County MONTGOMERY	10c. City, Town or Location SILVER SPRING				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9306 PINEY BRANCH RD #205		10f. Zip Code 20903				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) COOK		16b. Kind of Business/Industry NATIONAL INSTITUTE OF HEALTH		17. Father's Name (First, Middle, Last) LONNIE MASON, SR.	
18. Mother's Name (First, Middle, Maiden Surname) CARRIE THOMPSON		19a. Informant's Name/Relationship (Type, Print) EUGENE MASON/BROTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9306 PINEY BRANCH RD, #205, SILVER SPRING, MD 20903			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS		Date 2-5-2007	20c. Location - City or Town, State CHELTONHAM, MD		
21. Signature of Funeral Service Licensee J. P. Marshall		22. Name and Address of Funeral Home MARSHALLS FUNERAL HOME OF MD, INC 4308 SUITLAND RD, SUITLAND, MD 20746					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. Aspirati- Due to (or as a consequence of): Pneumonia.							
b. Dementia Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral vascular Accident							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide	
28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
M		M					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number DY5660				29d. Date signed (Month, Day, Year) 1/23/07	
30. Name and address of person who completed cause of death (in 28a) (Type, Print) 14300, CALCANTEX CON. 124 BAPTIST		32. Registrar's Signature 					
31. Date filed (Month, Day, Year) JAN 29 2007							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04072

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James A. McKeown, Sr.					2. Date of Death Month Day Year January 26, 2007	3. Time of Death 3:30 p.m.							
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery								
Funeral Director	5. Social Security Number 249-26-5171	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 1, 1924	9. Birthplace (State or Foreign Country) South Carolina							
	Usual Residence of Decedent 10a. State Maryland			10b. County Montgomery			10c. City, Town or Location Wheaton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 12714 Goodhill Road			10f. Zip Code 20906		10g. Citizen of What Country? USA								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Agent			16b. Kind of Business/Industry Insurance								
	17. Father's Name (First, Middle, Last) Guyden F. McKeown			18. Mother's Name (First, Middle, Maiden Surname) Fannie Bice										
	19a. Informant's Name/Relationship (Type. Print) Vardina S. McKeown/ Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12714 Goodhill Road, Wheaton, MD 20906										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metropolitan Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date Jan. 27, 2007	20c. Location - City or Town, State Alexandria, Virginia							
	21. Signature of Funeral Service Licensee Andrew J. Cole			22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901										
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury) that initiated events resulting in death) Last a. Lung Cancer Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown			23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) January 26, 2007	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State) Silver Spring, MD 20910										
	29a. Certifier (Check only one) Maria Tayag, M.D.			29b. Signature and title of certifier Maria Tayag, M.D.			29c. License number D63579			29d. Date signed (Month, Day, Year) January 26, 2007				
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007			32. Registrar's Signature Brian A. Jones										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 04073

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDNA HATTIE POSEY MARBURY							2. Date of Death Month Day Year JANUARY 27, 2007	3. Time of Death 11:32 A M	
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HEALTH & REHABILITATION CENTER				4b. City, Town, or Location of Death FORT WASHINGTON			4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 214-32-9154	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) MARCH 8, 1909	9. Birthplace (State or Foreign Country) MARYLAND			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MARYLAND 10b. County CHARLES				10c. City, Town or Location BRYANS ROAD			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 6590 WARD PLACE				10f. Zip Code 20616			10g. Citizen of What Country? UNITED STATES		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry HOME MAKER			
	17. Father's Name (First, Middle, Last) GEORGE POSEY				18. Mother's Name (First, Middle, Maiden Surname) NANCY JACKSON POSEY					
	19a. Informant's Name/Relationship (Type, Print) WILLIAM A. POSEY / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8920 JACKSONTOWN ROAD, NANJEMOY, MARYLAND 20662					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CHURCH CFM.			Date FEBRUARY 1, 2007 20c. Location - City or Town, State POMONKEY, MARYLAND		
	21. Signature of Funeral Service Licensee LYDIA C. THORNTON JOHNSON MO0583				22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Coronary Heart Disease</i></p> <p>b. Due to (or as a consequence of): <i>Atherosclerotic Cardiovascular Disease</i></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>									
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number 042955			29d. Date signed (Month, Day, Year) 1/29/07		
	29b. Signature and title of certifier <i>Laura B. Spack</i>									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11709 Columbia Rd Ft Washington Md 20744				32. Registrar's Signature <i>Laura B. Spack</i>					
	31. Date filed (Month, Day, Year) JAN 30 2007				33. Date signed (Month, Day, Year)					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04074
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Lang Manzer							2. Date of Death Month January Day 23 Year 2007	3. Time of Death 7:05 p M
	4a. Facility Name (If not institution, give street and number) Dove House Carroll Hospice			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 219-20-6966	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov 23, 1926	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland 10b. County Carroll 10c. City, Town or Location Westminster							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 104 Brookview Court				10f. Zip Code 21157		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Supervisor			16b. Kind of Business/Industry Telephone Company		
	17. Father's Name (First, Middle, Last) George Lang					18. Mother's Name (First, Middle, Maiden Surname) Elsie Hopkins			
	19a. Informant's Name/Relationship (Type, Print) Nancy L. Smedley, daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Brookview Court, Westminster, MD 21157			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Woodlawn Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 01/27/2007	20c. Location - City or Town, State Woodlawn MD		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Justin R. Durboraw					22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, check, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Failure Approximate Interval Between Onset and Death 3 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Cancer Congestive Heart Failure Approximate Interval Between Onset and Death 5 yrs 4 yrs								
	a. Due to (or as a consequence of): Renal Failure								
	b. Due to (or as a consequence of): Renal Cancer								
	c. Due to (or as a consequence of): Congestive Heart Failure								
	d.								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Inpatient Hospital								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28d. Describe how injury occurred Inpatient Hospital								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier John W. Middleton MD								
	29c. License number 125443								
	29d. Date signed (Month, Day, Year) 1/24/2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton 688 Rock Rd, Westminster, MD 21157								
	31. Date filed (Month, Day, Year) JAN 25 2007								
	32. Registrar's Signature John W. Middleton								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL
10State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04075

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Alice C Mariner							01 23 07	04:00 PM
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Atlantic General Hospital			Berlin MD			Worcester		
	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct. 1, 1914	9. Birthplace (State or Foreign Country) VA		
	Usual Residence of Decedent								
	10a. State MD	10b. County Worcester	10c. City, Town or Location Berlin					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 200 Franklin Ave.				10f. Zip Code 21811			10g. Citizen of What Country? US	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Registered Nurse				
	17. Father's Name (First, Middle, Last) Hite Columbus Camden				18. Mother's Name (First, Middle, Maiden Surname) Estoria Ligon Mann				
	19a. Informant's Name/Relationship (Type, Print) William C. Mariner (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6735 Rum Point Lane, Berlin, Md. 21811				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		Date 2-4-2007	20c. Location - City or Town, State Berlin, Maryland			
	21. Signature of Funeral Service Licensee 								
	22. Name and Address of Facility The Burbage Funeral Home 103 William St., Berlin, Md. 21811								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death)								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. Due to (or as a consequence of): Aspiration Pneumonia</p> <p>b. Due to (or as a consequence of): Dehydration</p> <p>c. Due to (or as a consequence of): Dementia</p> <p>d.</p>								
	Approximate Interval Between Onset and Death								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 				29c. License number D64645		29d. Date signed (Month, Day, Year) 01/23/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patty S. Ohnum MD 9733 Healthway Drive Berlin MD 21811								
	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 						

ORIGINAL

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division of Vital Records, P.O. Box 68760,

State
Registrar

E.T. 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

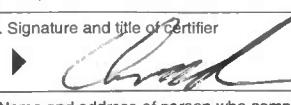
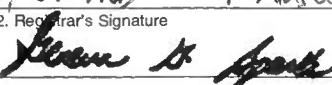
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 076

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Herman Miles							2. Date of Death Month JAN Day 29 Year 2007	3. Time of Death 1815 M
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 218-48-5464	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 07-17-1918	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent 10a. State MD 10b. County Somerset			10c. City, Town or Location Princess Anne			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 31820 Dublin Road			10f. Zip Code 21853			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) none		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Agriculture			
	17. Father's Name (First, Middle, Last) Aston T. Miles			18. Mother's Name (First, Middle, Maiden Surname) Annie Chesser					
	19a. Informant's Name/Relationship (Type, Print) Mike Miles/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31820 Dublin Road, Princess Anne, MD 21853					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Downing Cemetery		Date	20c. Location - City or Town, State Oak Hall, Virginia			
To Be Completed by Physician/Medical Examiner	Signature of Funeral Service Licensee John L. Herman M00295		22. Name and Address of Facility Hinman Funeral Home		11673 Somerset Avenue, Princess Anne, MD 21853				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): pneumonia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 weeks								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number D30853			29d. Date signed (Month, Day, Year) 1/30/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles B. Silva, Jr. MD Peninsula Regional Medical Center Salisbury MD 21801								
State Registrar	31. Date filed (Month, Day, Year) FEB 02 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04077

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Angeline Marie Finamore Norris							2. Date of Death Month Day Year February 6, 2007	3. Time of Death 12:30A M	
	4a. Facility Name (If not institution, give street and number) Charles County Nursing Rehab			4b. City, Town, or Location of Death La Plata			4c. County of Death Charles			
Funeral Director	5. Social Security Number 205-05-7131	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) September 20, 1920	9. Birthplace (State or Foreign Country) PA			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Charles 10c. City, Town or Location Welcome							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 8295 Melody Acres Drive			10f. Zip Code 20693			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Nicholas Tucci				18. Mother's Name (First, Middle, Maiden Surname) Catherine Stagliano					
	19a. Informant's Name/Relationship (Type, Print) Thomas Norris/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8295 Melody Acres Dr. Welcome, MD 20693					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► David C. Echols		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem. 2/9/07			Date 2/9/07	20c. Location - City or Town, State Cheltenham, Maryland			
	21. Signature of Funeral Service Licensee ► David C. Echols		M00945 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD 20646							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Terminal pneumonia								Approximate Interval Between Onset and Death 3 days	
	<p>a. Due to (or as a consequence of): Terminal pneumonia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier ► J. Hussein, MD		29c. License number D55455			29d. Date signed (Month, Day, Year) 2-6-07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fatima Hussein, M.D. 5625 Allentown Rd. Suite 101, Camp Springs, MD									
	31. Date filed (Month, Day, Year) FEB 09 2007		32. Registrar's Signature Jean B. Apelt							

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registration
AMEND#26perMD1/29/07, BMW, MoCo

Certificate of Death

Reg. No. 2007 04078

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty W. Nevitt					2. Date of Death Month Day Year January 22, 2007	3. Time of Death 2:25 a M	
	4a. Facility Name (If not institution, give street and number) Molly's House of Hope			4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles		
Funeral Director	5. Social Security Number 578-34-7210	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 81	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) Aug. 11, 1925	9. Birthplace (State or Foreign Country) Delaware		
	Usual Residence of Decedent 10a. State Maryland			10b. County Charles		10c. City, Town or Location Ta Plata		
To Be Completed by Funeral Director	10e. Street and Number 1035 Wales Drive			10f. Zip Code 20646	10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4 or 5+) 4	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Athletic Director/Educator	16b. Kind of Business/Industry Holton-Arms School			
	17. Father's Name (First, Middle, Last) William McKenna Woods			18. Mother's Name (First, Middle, Maiden Surname) Mary Short Davenport				
	19a. Informant's Name/Relationship (Type, Print) William G. Nevitt/ son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1035 Wales Drive, La Plata, Maryland 20646					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► <i>Willie J. Byrd</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery	Date Jan. 27, 2007	20c. Location - City or Town, State Washington, DC			
	21. Signature of Funeral Service Licensee ► <i>Willie J. Byrd</i>		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death unknown	
	<p>a. <i>atherosclerotic cardiovascular disease</i> Due to (or as a consequence of): </p> <p>b. <i>hypothyroidism</i> Due to (or as a consequence of): </p> <p>c. <i>hypertension</i> Due to (or as a consequence of): </p> <p>d. _____</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Assisted Living Facility					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ► <i>Robert T. Pace MD</i>		29c. License number DOO22574					
	29b. Signature and title of certifier ► <i>Robert T. Pace MD</i>		29d. Date signed (Month, Day, Year) 1/24/2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert T. Pace MD 12070 Old Line Cr., #302, Waldorf, MD 20602							
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature <i>Robert T. Pace</i>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04079

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
PERENETTER PHILLIPS		JANUARY 21, 2007		1:35 aM
4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL		4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY
5. Social Security Number 462-77-0709		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min.
				8. Date of Birth (Month, Day, Year) Dec 22, 1930
				9. Birthplace (State or Foreign Country) Liberia
10a. State Md.		10b. County Montgomery	10c. City, Town or Location Gaithersburg	
10e. Street and Number 9232 Hummingbird Terrace		10f. Zip Code 20879		10g. Citizen of What Country? Liberia
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Seamstress	16b. Kind of Business/Industry Clothing	
17. Father's Name (First, Middle, Last) James T. Phillips		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Woods		
19a. Informant's Name/Relationship (Type, Print) Precious Whitfield/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9232 Hummingbird Terrace Gaithersburg, Md. 20879		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Duport Rd. Cemetery	Date 2-13-07	20c. Location - City or Town, State Monrovia, Liberia
21. Signature of Funeral Service Licensee <i>Sharon Johnson Kelley</i>		22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Washington, D.C. 20002		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. CARDIOPULMONARY FAILURE Due to (or as a consequence of):				
b. CONGESTIVE HEART FAILURE Due to (or as a consequence of):				
c. END STAGE AORTIC STENOSIS Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE PULMONARY HYPERTENSION		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28g. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>SALIM AZIZ, M.D.</i>		29c. License number 58434		29d. Date signed (Month, Day, Year) 01/26/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALIM AZIZ, M.D.		31. Date filed (Month, Day, Year) JAN 29 2007		
		32. Registrar's Signature <i>Benard G. Scott</i>		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04080

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CECILIA IMOGEN V. PORTER					2. Date of Death Month Day Year January 25, 2007	3. Time of Death 11:20 PM		
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 220-35-9761	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 22, 1952	If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 22, 1952	9. Birthplace (State or Foreign Country) Philippines			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 915 Crestfield Drive			10f. Zip Code 20850	10g. Citizen of What Country? United States				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Filipino	14. Race - American Indian, Black, White, etc. Specify: Filipino					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pastor	16b. Kind of Business/Industry Christian Ministry					
	17. Father's Name (First, Middle, Last) Fortunato A. Vailoces			18. Mother's Name (First, Middle, Maiden Surname) Paz C. Ouano					
	19a. Informant's Name/Relationship (Type, Print) Joseph O.C. Porter (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Crestfield Dr. Rockville, Md. 20850						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cebu Memorial Park	Date Feb. 4, 2007	20c. Location - City or Town, State Cebu, Philippines				
	21. Signature of Funeral Service Licensee Curtis E. Day		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877						
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Renal Cell Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c. d. Due to (or as a consequence of): Approximate Interval Between Onset and Death Months								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0064115			29d. Date signed (Month, Day, Year) January 27, 2007			
	29b. Signature and title of certifier Kelly Mercer M.D.		29c. License number D0064115			29d. Date signed (Month, Day, Year) January 27, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kelly Mercer M.D. 9707 Medical Center Drive Suite#300 Rockville, Md. 20850								
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature Janet L. Jones						

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

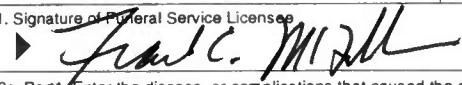
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04081

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Evelyn Propper							2. Date of Death Month JANUARY Day 26 Year 2007			3. Time of Death 1:30 A M	
	4a. Facility Name (If not institution, give street and number) Calvert Manor Healthcare Center			4b. City, Town, or Location of Death Rising Sun				4c. County of Death Cecil				
Funeral Director	5. Social Security Number 093-22-8309		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 14, 1915	9. Birthplace (State or Foreign Country) New York				
	10a. State Maryland		10b. County Cecil		10c. City, Town or Location Rising Sun			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 1881 Telegraph Road				10f. Zip Code 21911			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Samuel Dreisin			18. Mother's Name (First, Middle, Maiden Surname) Anna Victor								
19a. Informant's Name/Relationship (Type, Print) Wylie Propper/Grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Persimmon Drive, Little Egg Harbor Twp NJ 08087								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) R.T. Foard Funeral Home, P.A.			20b. Place of Disposition (Name of cemetery, crematory or other place) R.T. Foard Funeral Home, P.A.			Date 1-29-2007	20c. Location - City or Town, State Rising Sun, Maryland					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ c. _____ d. _____										Approximate Interval Between Onset and Death		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier 		29c. License number H58419				29d. Date signed (Month, Day, Year) JANUARY 26, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODNEY DONHAM, D.O. 1881 TELEGRAPH ROAD, RISING SUN, MD 21911										31. Date filed (Month, Day, Year) JAN 29 2007		
32. Registrar's Signature 										33. Date filed (Month, Day, Year)		

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. *If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at all times.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in **Indelible Ink**. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04082
Rag. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl B. Powell				2. Date of Death Month Day Year January 29, 2007	3. Time of Death 8:45p M	
	4a. Facility Name (If not institution, give street and number) Sunbridge Care		4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil		
Funeral Director	5. Social Security Number 218-16-9956	6. Sex <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) September 25, 1917	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Cecil	10c. City, Town or Location Elkton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 109 West Thomson Dr.			10f. Zip Code 21921	10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Household	
	17. Father's Name (First, Middle, Last) Alfred Bozman			18. Mother's Name (First, Middle, Maiden Surname) Lydia McDorman			
	19a. Informant's Name/Relationship (Type, Print) Peggy Vlamis/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 Childs Rd., Elkton, MD 21921		
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) R.A. Ferris Inc.		20b. Place of Disposition (Name of cemetery, crematory or other place) January 31, 2007		Date January 31, 2007	20c. Location - City or Town, State West Chester, PA	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Andrew G. Gee Funeral Home 259 E. Main St., Elkton, MD 21921		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death 1 week 1 w/c Since 1997 2 weeks		
	<p>a. Due to (or as a consequence of): Acute Respiratory Failure</p> <p>b. Due to (or as a consequence of): Pneumonia</p> <p>c. Due to (or as a consequence of): Atrial fibrillation -</p> <p>d. Due to (or as a consequence of): Pleural effusion</p>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident Recat Andrea - 20lb weight loss						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	24a. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death Check only one <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Residence		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) 123 Singletary Ave Elkton, MD 21921		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. JAYANTILAL K. PATEL MD				29c. License number D22307	29d. Date signed (Month, Day, Year) JAN 30 2007	
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #29d, per PHYS., G864, 2/9/07, WS

State of Maryland / Department of Health and Mental Hygiene

2007 04083

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death	
	Thelma June Rudy				February 1, 2007		9:10 A M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
	Beverly Healthcare			Hagerstown		Washington	
	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 6, 1927	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. State Maryland	10b. County Washington	10c. City, Town or Location Hagerstown				
	10e. Street and Number 19808 Jefferson Blvd.			10f. Zip Code 21742		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Knitting Mill	
	17. Father's Name (First, Middle, Last) Arthur E. Kendall			18. Mother's Name (First, Middle, Maiden Surname) Maude Webb			
	19a. Informant's Name/Relationship (Type, Print) Patricia A. Lengel (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19808 Jefferson Blvd. Hagerstown, Maryland 21742				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Cemetery		Date February 5, 2007	20c. Location - City or Town, State Smithsburg, Maryland		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
	Immediate Cause (Final disease or condition resulting in death)						
	a. Congestive Heart Failure Due to (or as a consequence of):						
	b. Atrial Fibrillation Due to (or as a consequence of):						
	c. Pneumonia Due to (or as a consequence of):						
	d. Diabetes Mellitus Due to (or as a consequence of):						
	Approximate Interval Between Onset and Death Years						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						
	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 						
	29c. License number 80045031						
	29d. Date signed (Month, Day, Year) Feb 3 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19414 C Center Court Pike Hagerstown MD 21742						
	31. Date filed (Month, Day, Year) FEB 09 2007						
	32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, EC

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04084

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Sylvia Robertson
Baltimore, Maryland 21215-0036

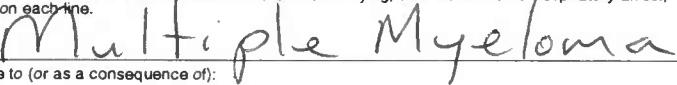
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Physician

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Jacqueline Robertson		1 Month 26 Day 07 Year				2:30 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
107 Deerfield Road		Elkton				Cecil	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
236-50-9311			84 Yrs.			05/21/1922	West Virginia
10a. State MD		10b. County Cecil	10c. City, Town or Location Elkton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 107 Deerfield Road		10f. Zip Code 21921				10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Alvin Hobart Predew				18. Mother's Name (First, Middle, Maiden Surname) Margaret Bandy			
19a. Informant's Name/Relationship (Type, Print) Kathy J. Creed / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Deerfield Road, Elkton, MD 21921					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park				Date 1/29/2007	20c. Location - City or Town, State Elkton, MD
21. Signature of Funeral Service Licensed 		22. Name and Address of Facility Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): 				Approximate Interval Between Onset and Death 1 yr	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):					
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
23f. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number Gloria Simonson MD #0056449				29d. Date signed (Month, Day, Year) 1/29/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson MD 111 West High St. Suite 302 Elkton MD 21921		32. Registrar's Signature 				31. Date filed (Month, Day, Year) JAN 31 2007	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 085

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred M. Riggs				2. Date of Death Month Day Year January 23, 2007	3. Time of Death 11:15 am M		
	4a. Facility Name (If not institution, give street and number) 1125 Colony Ridge Road		4b. City, Town, or Location of Death Odenton		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 215-26-6116	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) MAY 29 1930	9. Birthplace (State or Foreign Country) Mineola, NY		
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel				10c. City, Town or Location Odenton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1125 Colony Ridge Road			10f. Zip Code 21113	10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 03		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse	16b. Kind of Business/Industry Public Health				
	17. Father's Name (First, Middle, Last) Ernest Marando			18. Mother's Name (First, Middle, Maiden Surname) Mildred Guida				
	19a. Informant's Name/Relationship (Type, Print) Laura Riggs		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 Court Revere Odenton, MD 21113					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Epiphany Cemetery	Date Jan 28 2007	20c. Location - City or Town, State Odenton, MD			
	21. Signature of Funeral Service Person 		22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis Road Gambrills, MD 21054					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 18 MONTHS	
	<p>a. AMYOTROPHIC LATERAL SCLEROSIS Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) DEFENSE HIGHWAY, SUITE 400 ANNAPOLIS, MD 21401		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D&#61776		29d. Date signed (Month, Day, Year) JANUARY 25 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN E. WOLF							
	31. Date filed (Month, Day, Year) JAN 26 2007		32. Registrar's Signature 					

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04086

1- For State Registrar

Spurlock, Larry
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death		
LARRY GENE SPURLOCK	Month	Day	Year
4a. Facility Name (If not institution, give street and number)	4c. County of Death		
Franklin Square Hospital	Baltimore		
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death
212-54-9354	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	57 Yrs.	Rosedale
8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
2/28/1949	New Jersey		
Usual Residence of Decedent			
10a. State	10b. County	10c. City, Town or Location	
MD.	Harford	White Hall	
10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?
4426B Norrisville Road		21161	United States
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
15. Decedent's Education (Specify only highest grade completed)		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
Elementary/Secondary (0-12) 9	College (1-4 or 5+) 0	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
James Harrison Spurlock Sr.		Mildred Louise Reedy	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Sandra M. Spurlock/Wife		21161 4426B Norrisville Rd. White Hall, Md.	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Carroll Cremation	2/5/2007
21. Signature of Funeral Service Licensee		22. Name and Address of Facility	
► M. Blacken Kurtz		Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A.	

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)			
a. MI			
Due to (or as a consequence of):			
b. Septic Shock			
Due to (or as a consequence of):			
c. Acute Renal Failure			
Due to (or as a consequence of):			
d.			
IF FEMALE:			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
Multiple organ dysfunction CAD COPD			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)	
		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier ► Binh Nguyen	
		29c. License number 00065094	29d. Date signed (Month, Day, Year) 2-2-7
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) FEB 09 2007	
Dr. Binh Nguyen 9000 Franklin Sq. Drive Baltimore, md 21231		32. Registrar's Signature Jean B. Jones	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 087
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Virginia Short					2. Date of Death Month Day Year Feb 4, 2007	3. Time of Death 9:05 pm M		
	4a. Facility Name (If not institution, give street and number) Beverly Living Center of Cumberland			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany			
Funeral Director	5. Social Security Number 214-05-7096	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Apr 21, 1907	9. Birthplace (State or Foreign Country) WV		
	Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Cumberland 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Funeral Director	10e. Street and Number 135 N. Mechanic Street Apt. 1105			10f. Zip Code 21502		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Laborer			16b. Kind of Business/Industry Footers Dye Works			
	17. Father's Name (First, Middle, Last) Albert L. Short			18. Mother's Name (First, Middle, Maiden Surname) Nannie B. (Marker) Short					
	19a. Informant's Name/Relationship (Type, Print) Phyllis Hare niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 S. Belcher Road Largo FL 33771						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Ashby Cemetery		Date 2/7/2007	20c. Location - City or Town, State Fort Ashby WV			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue, Cumberland, MD 21502					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal failure							Approximate Interval Between Onset and Death 4 weeks	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Stenosis								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	24. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 							29c. License number D04981	
								29d. Date signed (Month, Day, Year) February 5, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER HALMS 10000 Carrington Court, Cumberland, MD 21502								
	31. Date filed (Month, Day, Year) FEB 09 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b,20c,perFH,G804,2/9/07,w

State of Maryland / Department of Health and Mental Hygiene

ne 2007 04088

Reg. No.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) John Charles Stark				2. Date of Death Month Day Year Feb. 3, 2007		3. Time of Death 5:45 p M		
Funeral Director		4a. Facility Name (If not institution, give street and number) Cumberland Villa Nursing Center				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
To Be Completed by Funeral Director		5. Social Security Number 216-38-1783		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs, last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 18, 1939	9. Birthplace (State or Foreign Country) Maryland	
		Usual Residence of Decedent 10a. State MD		10b. County Allegany		10c. City, Town or Location LaVale			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 604 N. Fourth Street				10f. Zip Code 21502		10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1958 1964		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify:		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Engineer Tech			16b. Kind of Business/Industry Defense		
		17. Father's Name (First, Middle, Last) John Walter Stark				18. Mother's Name (First, Middle, Maiden Surname) Grace E. (Erdman) Stark				
		19a. Informant's Name/Relationship (Type, Print) Nancy Stark Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 N. Fourth Street, LaVale, MD 21502					
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) STUBBAUGH CREMATORIUM			20b. Place of Disposition (Name of place) Rocky Gap Veteran Cem		Date 2-5-07	20c. Location - City or Town, State Uniontown, PA		
		21. Signature of Funeral Service Licensee John J. Hafer, Jr.			22. Name and Address of Facility Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD 21502					
Physician /Medical Examiner		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 36 hrs
		<p>a. Due to (or as a consequence of): Aspiration pneumonia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				3. Ectopic pregnancy <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ursepsis								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) February 4, 2007
		29b. Signature and title of certifier Peter Halmus MD		29c. License number DO 4981						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER HALMUS 10000 Carrington Court, Cumberland, MD 21502		32. Registrar's Signature See back for specific						
		31. Date filed (Month, Day, Year) FEB 12 2007		33. Registrar's Signature						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1- State Registrars

Baltimore, Maryland 21215-0036

**Physician
/Medical
Examiner**

State
Registrar

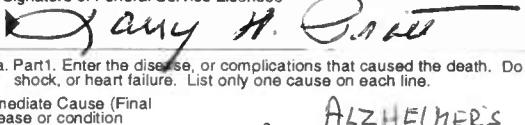
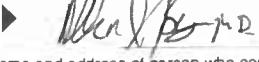
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#4c.PerPhys.PGC1-29-07cr

Certificate of Death

Reg. No. 2007 04089

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DELORES KARINA SIMMONS							2. Date of Death Month 1 Day 25 Year 07	3. Time of Death 7:40A-M		
	4a. Facility Name (If not institution, give street and number) CRESLENT CITY			4b. City, Town, or Location of Death RIVERDALE, MARYLAND			4c. County of Death PRINCE GEORGE'S				
Funeral Director	5. Social Security Number 577-48-3434	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 2/11/34	9. Birthplace (State or Foreign Country) Wash., D.C.				
	Usual Residence of Decedent 10a. State Md. 10b. County Prince George's			10c. City, Town or Location Cottage City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 4012 Parkwood Court			10f. Zip Code 20722			10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Program Analyst			16b. Kind of Business/Industry U.S. Government					
17. Father's Name (First, Middle, Last) Robert Mills					18. Mother's Name (First, Middle, Maiden Surname) Gladys Sykes						
19a. Informant's Name/Relationship (Type, Print) Gregory Simmons/Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4012 Parkwood Court, Cottage City, Maryland 20722						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park			Date 2/2/07	20c. Location - City or Town, State Landover, Md.				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility H.S.Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death						
a. ALZHEIMER'S DISEASE Due to (or as a consequence of):											
b. _____ Due to (or as a consequence of):											
c. _____ Due to (or as a consequence of):											
d. _____											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA HYPERTENSION					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) 1-25-07			
29b. Signature and title of certifier 					29c. License number D 25914						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLEN BRIMMER, M.D. 4409 EAST-WEST HIGHWAY, RIVERDALE, MARYLAND 20737											
31. Date filed (Month, Day, Year) JAN 29 2007			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 090

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

Usual Residence of Decedent

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 8:10 PM
UNICE V. SETTLES		JAN. 19, 2007		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES
5. Social Security Number 577 70 2281		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	8. Date of Birth (Month, Day, Year) 6-12-1950
9. Birthplace (State or Foreign Country) WASH. DC.		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State D.C.		10b. County		10c. City, Town or Location WASHINGTON, D.C.
10e. Street and Number 4432 FALLS TERR. S.E. #1		10f. Zip Code 20019		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12 yrs.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY		16b. Kind of Business/Industry FEDERAL GOVERNMENT
17. Father's Name (First, Middle, Last) THOMAS W. MOORE		18. Mother's Name (First, Middle, Maiden Surname) UNICE M. POWELL		
19a. Informant's Name/Relationship (Type, Print) NATHAN A. SETTLES / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 FRAZER CREEK RD. WINSTON SALEM NC 27105		Date
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MARYLAND NAT.		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State LAUREL, MD
21. Signature of Funeral Service Licensee James J. Miller		22. Name and Address of Facility JAMES T. RHINES FUNERAL HOME 3015 - 12th ST NE WASH DC 20017		Approximate Interval Between Onset and Death
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. FATAL CARDIAC ARRHYTHMIA Due to (or as a consequence of): CONGESTIVE HEART FAILURE Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): DIABETES</p>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3001 HOSPITAL DR		28f. Location (Street and Number or Rural Route Number, City or Town, State) CHEVERLY, MD 20785
29b. Signature and title of certifier GARY LITTLE		29c. License number D58957		29d. Date signed (Month, Day, Year) 1-22-07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR GARY LITTLE				
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature Brian B. Parker		

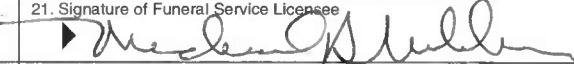
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04091

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Lou Stafford					2. Date of Death Month January Day 27 , Year 2007	3. Time of Death 5:35 A.M.	
	4a. Facility Name (If not institution, give street and number) 1 Bracknell Circle			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 190-26-4743	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept. 10, 1935	9. Birthplace (State or Foreign Country) PA.	
	Usual Residence of Decedent Maryland Montgomery			10c. City, Town or Location Rockville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1 Bracknell Circle			10f. Zip Code 20850		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Superintendent			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Construction	
	17. Father's Name (First, Middle, Last) Robert Anderson				18. Mother's Name (First, Middle, Maiden Surname) Anna Guyton			
	19a. Informant's Name/Relationship (Type, Print) Richard C. Stafford/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Bracknell Circle, Rockville, Maryland 20850				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory	Date 1/27/2007	20c. Location - City or Town, State Alexandria, Virginia		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877				
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Metastatic Non Small Cell Lung Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death Months</p>							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p>							
				<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<p>26. Place of Death (Check only one)</p> <p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	<p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number D0064115</p> <p>29d. Date signed (Month, Day, Year) January 27, 2007</p>							
	<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Mercer, M.D., 9707 Medical Center Drive, Suite 300, Rockville, Maryland 20850</p>							
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>31. Date filed (Month, Day, Year) JAN 29 2007</p> <p>32. Registrar's Signature </p>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04092

Reg. No.

1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Toshikazu Sekine

2. Date of Death
Month Day Year
January 23, 2007

3. Time of Death
2:10 PM

Physician
/Medical
Examiner

4a. Facility Name (If not institution, give street and number)

1916 CHAPEL HILL ROAD

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

6. Sex

M

F

7. Age (In yrs. last birthday)

Yrs.

68

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth
(Month, Day, Year)

JUNE 28, 1938

9. Birthplace (State or Foreign
Country)

JAPAN

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

MARYLAND

MONTGOMERY

SILVER SPRING

Yes No

10e. Street and Number

1916 CHAPEL HILL ROAD

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ASIAN

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CHEF

16b. Kind of Business/Industry

BAKERY

17. Father's Name (First, Middle, Last)

YUZO SEKINE

18. Mother's Name (First, Middle, Maiden Surname)

SHIGENO SUMITA

19a. Informant's Name/Relationship (Type, Print)

ANTHONY TU-SEKINE - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1916 CHAPEL HILL ROAD, SILVER SPRING, MARYLAND 20904

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NATIONAL MEMORIAL PARK

Date

1/29/2007

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

13 MONTHS

a. NON-SMALL CELL LUNG CANCER

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?
 Yes No

Hospital:

Inpatient ER/Outpatient DOA

Other:

Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending investigation
 Accident Could not be determined
 Suicide Homicide

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

00061040

29d. Date signed (Month, Day, Year)

01/25/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles R. J. MD PhD

401 N. Broadway

Baltimore MD 21231

31. Date filed (Month, Day, Year)

JAN 29 2007

32. Registrar's Signature


Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 093

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Talbert M. Styles							2. Date of Death Month Day Year JANUARY 22 2007	3. Time of Death 9:55 PM
	4a. Facility Name (If not institution, give street and number) Harbor Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death		
Funeral Director	5. Social Security Number 225-38-3624	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/16/1935	9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	10a. State MD.			10b. County Anne Arundel	10c. City, Town or Location Severn			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 7912 Severn Hills Way			10f. Zip Code 21144			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed			16b. Kind of Business/Industry Trash Service		
	17. Father's Name (First, Middle, Last) Arsenia Styles			18. Mother's Name (First, Middle, Maiden Surname) Althea Allen					
	19a. Informant's Name/Relationship (Type, Print) Frederick Styles (son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7912 Severn Hills Way, Severn, Md. 21144					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Sulpitius Springs Baptist Church Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) January 28, 2007			20c. Location - City or Town, State Prospect, Virginia		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Jean A. Spada 10/26/01			22. Name and Address of Facility Carl V. Eggleston Funeral Estab. 914 S. Main St., Farmville, Va. 23901					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death immediate		
	a. CARDIAC dysrhythmia Due to (or as a consequence of):								
	b. Coronary artery Disease Due to (or as a consequence of):								
	c. HYPERTENSION Due to (or as a consequence of):								
	d. chronic Renal insufficiency								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) 9/Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. multiple myeloma						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier A. Bukovitz MD			29c. License number D0061438			29d. Date signed (Month, Day, Year) JANUARY 31, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW I. BUKOVITZ MD			31. Date filed (Month, Day, Year) FEB 07 2007			32. Registrar's Signature Anna B. Spada		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Amended Item 17 per F.D. 01/25/2007 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04094

1- For
State
Registrar

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WSV
20

State
Registrar

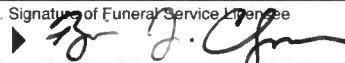
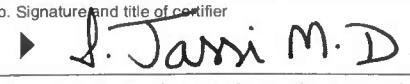
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death						
Mabel Elizabeth Still		January 23 2007 11:05 M										
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death						
Carroll Lutheran Village		Westminster				Carroll						
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov 21 1912		9. Birthplace (State or Foreign Country) MD				
6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.										
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 205 St. Mark Way Apt. 521				10f. Zip Code 21158				10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home								
17. Father's Name (First, Middle, Last) Clarence Clickner		18. Mother's Name (First, Middle, Maiden Surname) Edith Ijams										
19a. Informant's Name/Relationship (Type, Print) Linda Downs Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5709 Manor Dr. Woodbine, MD 21797										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 1/24/07		20c. Location - City or Town, State Hampstead, MD						
21. Signature of Funeral Service Licensee JK ASJ		22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Rd. Westminster, MD 21157										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Approximate Interval Between Onset and Death								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29b. Signature and title of certifier R. Paniswamy MD		29c. License number D 51705		29d. Date signed (Month, Day, Year) 1-23-07								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PANISWAMY 349 Malcolm DR, Westminster MD 21157												
31. Date filed (Month, Day, Year) JAN 25 2007		32. Registrar's Signature Glen K. Spotts										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For AMEND#29D Per Phy. State of Maryland / Department of Health and Mental Hygiene
1- State Registrar AACC HEALTH DEPT. 1/26/07 CMH

Certificate of Death

Reg. No. 2007 04095

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard Malcolm Stinchcomb Sr.				2. Date of Death Month Day Year January 21, 2007	3. Time of Death 2PM M
	4a. Facility Name (If not institution, give street and number) 1125 Sunrise Beach Road		4b. City, Town, or Location of Death Crownsville		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218-14-2123	6. Sex X M	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr 19 1924	If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Crownsville				10d. Inside City Limits 1 Yes X No	
	10e. Street and Number 1125 Sunrise Beach Rd			10f. Zip Code 21032	10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator	16b. Kind of Business/Industry Newspaper Delivery		
	17. Father's Name (First, Middle, Last) George Andrew Stinchcomb			18. Mother's Name (First, Middle, Maiden Surname) Elsie Edith Moran		
	19a. Informant's Name/Relationship (Type, Print) Evelyn Estelle Stinchcomb Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1125 Sunrise Beach Rd. Crownsville, MD 21032			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery	Date Jan 26 2007	20c. Location - City or Town, State Glen Burnie, MD	
Physician /Medical Examiner	21. Signature of Physician/Medical Examiner 		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
	<p>a. Due to (or as a consequence of): Congestive Heart Failure</p> <p>b. Due to (or as a consequence of): Coronary Artery Disease</p> <p>c. Due to (or as a consequence of): Diabetes Mellitus</p> <p>d. Due to (or as a consequence of): Years</p>					
	Approximate Interval Between Onset and Death 2 years 10 years Years					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure					
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred					
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 					
	29c. License number D54292					
	29d. Date signed (Month, Day, Year) Jan 22nd Jan 22, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. JASSI, 1600 CRAIN Hwy Suite 610, Glen Burnie, MD, 21061					
	31. Date filed (Month, Day, Year) JAN 26 2007		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04096

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Loren Leroy Smith</i>					2. Date of Death Month Day Year <i>Jan 26 2007</i>	3. Time of Death <i>3:08 PM</i>			
	4a. Facility Name (If not institution, give street and number) <i>Coastal Hospice at the Lake</i>			4b. City, Town, or Location of Death <i>Salisbury</i>		4c. County of Death <i>Wicomico</i>				
Funeral Director	5. Social Security Number <i>222-05-4039</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>90 Yrs.</i>	If Under 1 Year Months Days Hours Min. <i>7-29-1916</i>	8. Date of Birth (Month, Day, Year) <i>7-29-1916</i>	9. Birthplace (State or Foreign Country) <i>DELAWARE</i>				
To Be Completed by Funeral Director	10a. State <i>DELAWARE</i>			10b. County <i>SUSSEX</i>			10c. City, Town or Location <i>MILLSBORO</i>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>20071 WHITESVILLE ROAD</i>			10f. Zip Code <i>19966</i>			10g. Citizen of What Country? <i>US</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>8</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>WHITE</i>		14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>				
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 8</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+) FOREMAN</i>			16b. Kind of Business/Industry <i>ROOFING</i>				
	17. Father's Name (First, Middle, Last) <i>CLARENCE LEROY SMITH</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>BLANCHE CORDREY</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>ESTA M. SMITH / WIFE</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>20071 WHITESVILLE RD, MILLSBORO, DE. 19966</i>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>[Signature]</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>LINE METHODIST CHURCH CEMETERY</i>		Date <i>1-31-2007</i>	20c. Location - City or Town, State <i>WHITESVILLE, DELAWARE</i>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <i>MELSON FUNERAL SERVICES, LTD. THATCHER ST., FRANKFORD, DELAWARE. 19945</i>						
Physician /Medical Examiner	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Cerebrovascular Accident</i>								Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <i>1</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D26278</i>			29d. Date signed (Month, Day, Year) <i>1-26-07</i>				
SA 6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David E. Carroll, MD Coastal Hospice po Box 1733 Salisbury MD 21802</i>									
State Registrar	31. Date filed (Month, Day, Year) <i>JAN 30 2007</i>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 097

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) The Elma Carey Savage					2. Date of Death Month Day Year Jan. 27 2007	3. Time of Death 8:05 P M		
	4a. Facility Name (If not institution, give street and number) 308 West St.			4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester			
Funeral Director	5. Social Security Number 213-24-1636	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min. 0 0 0 0	8. Date of Birth (Month, Day, Year) April 21, 1931	9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent 10a. State MD			10b. County Worcester			10c. City, Town or Location Berlin		
To Be Completed by Funeral Director	10e. Street and Number 308 West St.			10f. Zip Code 21811		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1960		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria worker		16b. Kind of Business/Industry School				
	17. Father's Name (First, Middle, Last) Roland Carey, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Anna Hastings					
	19a. Informant's Name/Relationship (Type, Print) Roland Lee Savage		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8019 Ironshire Station Rd., Berlin, Md. 21811						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ragueline J. Bayle		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverside Cemetery		Date 1-31-2007	20c. Location - City or Town, State Libertytown, Md.			
	21. Signature of Funeral Service Licensee Ragueline J. Bayle		22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER		Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Stephen Waters MD		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen F Waters, MD 1001 Philadelphia Ave, Ocean City MD 21842						29c. License number 027993		
	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature Stephen F Waters						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

BA5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

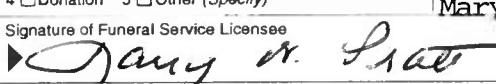
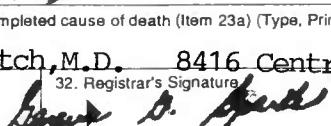
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04098

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death			
	Susie Cornelia Taylor							January 25, 2007	7:05 P.M.			
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death				
	Gladys Spellman Nursing Center				Cheverly			Prince George's				
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 10/7/23	9. Birthplace (State or Foreign Country) Wash., D.C.				
	577-36-8716											
Usual Residence of Decedent												
D.C.	10b. County		10c. City, Town or Location Washington					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 1221 M St., N.W.				10f. Zip Code 20005			10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic			16b. Kind of Business/Industry Private Industry						
17. Father's Name (First, Middle, Last) William Scrivner					18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Walker							
19a. Informant's Name/Relationship (Type, Print) Catherine Sneed/Niece										19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 58th Avenue # 6, Bladensburg, Md. 20710		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Nat'l. Mem. Park			Date 1/31/07	20c. Location - City or Town, State Laurel, Maryland			
21. Signature of Funeral Service Licensee 										22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
<p>a. Respiratory Failure Due to (or as a consequence of):</p> <p>b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):</p> <p>c. Congestive Heart Failure Due to (or as a consequence of):</p> <p>d. Non-Insulin Dependent Diabetes Mellitus</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D27577			29d. Date signed (Month, Day, Year) 1/26/07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, M.D. 8416 Central Avenue, Capitol Heights, Md. 20743												
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature 										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 0409

1 - For State Registrar		Decedent's Name (First, Middle, Last) Michael Armfield Van Bibber						2. Date of Death Month 1 Day 23 Year 2007	3. Time of Death 6:40 P.M.
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) 1225 Morris Road			4b. City, Town, or Location of Death Freeland			4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 315-36-1703	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/1/1935	9. Birthplace (State or Foreign Country) Hawaii	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Freeland						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 1225 Morris Road			10f. Zip Code 21053			10g. Citizen of What Country? United States	
Physician /Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1957-1961	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
Medical Certification: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Packaging Engineer			16b. Kind of Business/Industry Defense Department		
		17. Father's Name (First, Middle, Last) Col. Edwin Michael Van Bibber		18. Mother's Name (First, Middle, Maiden Surname) Julia Laurenson Lackey					
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Janet Rouse Van Bibber-Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1225 Morris Road, Freeland, Maryland 21053			Date		
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Carroll Cremation		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation			20c. Location - City or Town, State Hampstead, Maryland		
		21. Signature of Funeral Service Licensee Steven W. Eline		22. Name and Address of Facility Eline Funeral Home, 934 South Main Street, Hampstead, Maryland 21074					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia						Approximate Interval Between Onset and Death 2 weeks	
		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right side hemiplegia from old stroke						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and Title of certifier Barbara J. Davis			29c. License number D12801			29d. Date signed (Month, Day, Year) 1-24-2007	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Faustine MD 411 Love Buckeysville Road, Hampstead Md 21074							
		31. Date filed (Month, Day, Year) JAN 25 2007		32. Registrar's Signature Barbara J. Davis					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

WJL 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 100

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Randolph Williams				2. Date of Death Month Day Year Jan. 20, 2007	3. Time of Death 8:41 p m			
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges				
Funeral Director	5. Social Security Number 241-59-3587	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) Oct. 22, 1970	9. Birthplace (State or Foreign Country) Wash.D.C.			
	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
To Be Completed by Funeral Director	10a. State MD		10b. County Prince Georges	10c. City, Town or Location Temple Hills					
	10e. Street and Number 5927 Fisher Road #12			10f. Zip Code 20748	10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Chef Food Industry				
	17. Father's Name (First, Middle, Last) Alexander Williams			18. Mother's Name (First, Middle, Maiden Surname) Ida Diggs					
	19a. Informant's Name/Relationship (Type, Print) Theresa Crawford-Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5927 Fisher Rd.#12 Temple Hills, MD, 20748					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Pk Crem		Date Jan. 30, 07	20c. Location - City or Town, State Riverdale, MD			
	21. Signature of Funeral Service Licensee ► Francis B. Hunt			22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death Diseases Diabetes mellitus		
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Due to (or as a consequence of): a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Bacteremia						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 504 54			29d. Date signed (Month, Day, Year) January 21, 07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Cedar Hill Ave 3-418 Silver Spring MD 20902						31. Date filed (Month, Day, Year) JAN 29 2007		
	32. Registrar's Signature Randall B. Speaks								

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 101

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
JUDITH WINTER		JANUARY 26, 2007				2:35 A M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
17600 BOWIE MILL ROAD		ROCKVILLE				MONTGOMERY	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/22/1923	9. Birthplace (State or Foreign Country) POLAND
6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/22/1923	9. Birthplace (State or Foreign Country) POLAND	
Usual Residence of Decedent		10a. State MARYLAND 10b. County MONTGOMERY 10c. City, Town or Location ROCKVILLE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 17600 BOWIE MILL ROAD		10f. Zip Code 20855				10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) GUSTAV KAISER		18. Mother's Name (First, Middle, Maiden Surname) "UNKNOWN" LINZER					
19a. Informant's Name/Relationship (Type, Print) DR. CHARLES PADDACK SON-IN-LAW		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17600 BOWIE MILL ROAD, ROCKVILLE, MARYLAND 20855					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) JUDEAN MEML GDNS		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 01/28/2007	20c. Location - City or Town, State OLNEY, MARYLAND		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852					

To Be Completed by Funeral Director

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D39793				29d. Date signed (Month, Day, Year) JANUARY 26, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER J. MAYS, MD 18111 PRICE PHILIP DRIVE, OLNEY, MARYLAND 20832									
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
2007 04 02
Certificate of Death

1- For State Registrar		2. Date of Death Month Day Year JANUARY 26, 2007		3. Time of Death 10:00 A M	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE A. WICKMAN			4c. County of Death MONTGOMERY	
Funeral Director	4a. Facility Name (If not institution, give street and number) 1316 FENWICK LANE, APT. 904			4b. City, Town, or Location of Death SILVER SPRING	
To Be Completed by Funeral Director	5. Social Security Number 379-26-3731	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	8. Date of Birth (Month, Day, Year) AUGUST 19, 1930	
			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) MICHIGAN	
	Usual Residence of Decedent			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10a. State MARYLAND	10b. County MONTGOMERY	10c. City, Town or Location SILVER SPRING		
	10e. Street and Number 1316 FENWICK LANE, APT. 904			10f. Zip Code 20910	
				10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates & KOREAN	13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: WHITE	14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MILLWRIGHT	
	16b. Kind of Business/Industry AUTOMOTIVE				
	17. Father's Name (First, Middle, Last) GALE K. WICKMAN			18. Mother's Name (First, Middle, Maiden Surname) ELISE KENYON	
	19a. Informant's Name/Relationship (Type, Print) ALLEN E. WICKMAN/SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11101 RALSTON ROAD, ROCKVILLE, MARYLAND 20852	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GRAND LAWN CEMETERY	
				Date 01/31/2007	
	21. Signature of Funeral Service Licensee Amanda J. Ludwig			20c. Location - City or Town, State DETROIT, MICHIGAN	
	22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMPHYSEMA			Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28b. Time of Injury M
				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home	
				28f. Location (Street and Number or Rural Route Number, City or Town, State) At home	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Elizabeth L. COBBS, M.D.	
				29c. License number D0030626	29d. Date signed (Month, Day, Year) 1/26/07
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH L. COBBS, M.D., 50 IRVING STREET, N.W., WASHINGTON, DC 20422			31. Date filed (Month, Day, Year) JAN 29 2007	
				32. Registrar's Signature Barbara B. Jones	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or if Item 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04103

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leila D. White					2. Date of Death Month JAN. Day 26 Year 2007	3. Time of Death 1900 M	
	4a. Facility Name (If not institution, give street and number) Annisua Regional Medical Center					4b. City, Town, or Location of Death Salisbury	4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 218-16-9583	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 05-10-1914	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD 10b. County Somerset 10c. City, Town or Location Wenona					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 23000 Parkinson Road			10f. Zip Code 21821		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) none Homemaker		16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Charles Abbott			18. Mother's Name (First, Middle, Maiden Surname) Ethel Elliott				
	19a. Informant's Name/Relationship (Type, Print) Stella Beach/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22992 Parkinson Road, Wenona, MD 21821				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. Pauls Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Hinman Funeral Home		Date 01/30/2007	20c. Location - City or Town, State Wenona, Maryland	
	21. Signature of Funeral Service Licensee James L. Hinman			22. Name and Address of Facility M00295 11673 Somerset Avenue, Princess Anne, MD 21853				
Physician /Medical Examiner	23. a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Medical Certification: To Be Completed by Physician/Medical Examiner	23. b. Due to (or as a consequence of): Aspiration pneumonia							
	23. c. Due to (or as a consequence of):							
	23. d. Due to (or as a consequence of):							
	23. e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia Diabetes mellitus							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Alon Davis mo							
	29c. License number DS4127							
	29d. Date signed (Month, Day, Year) 1/27/07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Power St. Salisbury md 21804							
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature Leila D. White					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

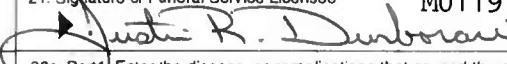
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04104

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Heather Yates							2. Date of Death Month Day Year January 29, 2007	3. Time of Death 2:35 p M				
	4a. Facility Name (If not institution, give street and number) Dove House Carroll Hospice				4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll					
Funeral Director	5. Social Security Number 220-42-0189	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month Day Year) Jul 6, 1936	9. Birthplace (State or Foreign Country) England				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland								10b. County Carroll	10c. City, Town or Location Eldersburg	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 2721 Old Liberty Road				10f. Zip Code 21784			10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chartographer			16b. Kind of Business/Industry State Of Maryland					
	17. Father's Name (First, Middle, Last) William Anthony Roberts					18. Mother's Name (First, Middle, Maiden Surname) Dorothy Ellen Woolls							
	19a. Informant's Name/Relationship (Type, Print) Frank Wielgus, husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2721 Old Liberty Road, Eldersburg, MD 21784							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) South Carroll Crematory			Date 01/30/2007	20c. Location - City or Town, State Winfield, MD						
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157										
	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death				
	<p>a. Breast Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None Known								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Inpatient			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred Hospice				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 			29c. License number D15552	29d. Date signed (Month, Day, Year) 1/30/07
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Sainz, M.D. 555 South Center Street Westminster, MD 21157								31. Date filed (Month, Day, Year) JAN 30 2007			32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

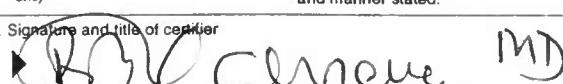
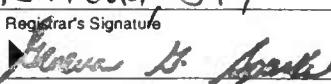
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04105

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise Carolyn Yeatman							2. Date of Death Month Day Year January 27, 2007	3. Time of Death 9:10 A M	
	4a. Facility Name (If not institution, give street and number) 3739 Turkeyfoot Rd.				4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 214-38-6589	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Oct. 17, 1939	9. Birthplace (State or Foreign Country) Annapolis, MD	
Usual Residence of Decedent										
	10a. State MD	10b. County Carroll	10c. City, Town or Location Westminster						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3739 Turkeyfoot Rd.				10f. Zip Code 21157				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department Manager			16b. Kind of Business/Industry Giant Food			
17. Father's Name (First, Middle, Last) Edwin Ray Frantam, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Louise Carolyn Hall						
19a. Informant's Name/Relationship (Type, Print) Daniel D. Yeatman - husband										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3739 Turkeyfoot Rd., Westminster, MD 21158				19c. Date 02/02/2007						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cemetery			20c. Location - City or Town, State Westminster, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritt's Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) C.H.F.										
Approximate Interval Between Onset and Death										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. Due to (or as a consequence of): C.O.P.D.</p> <p>b. Due to (or as a consequence of): C.A.D.</p> <p>c. Due to (or as a consequence of): Severe Rheumatoid Arthritis</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number J-0054218			29d. Date signed (Month, Day, Year) 01-28-2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RAMA R. Kaneria 349 Malcolm Drive, Westminster MD 21157										
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

NJL
10

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 106
Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Howard Lee Brown	February 09 2007	5:55 PM

4a. Facility Name (If not institution, give street and number)

ST AGNES HOSPITAL

4b. City, Town, or Location of Death

4c. County of Death

Funeral
Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 07 17 31	9. Birthplace (State or Foreign Country) TX
385-32-0582	75				

Usual Residence of Decedent
10a. State
MD
10b. County
NA
10c. City, Town or Location
Baltimore
10e. Street and Number
2657 Purnell Drive
10f. Zip Code
21207
10g. Citizen of What Country?
U.S.A.
11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc.
Specify: Black
15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) 2yrs
16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Owner
16b. Kind of Business/Industry
Browns Game World
17. Father's Name (First, Middle, Last)
Frederick Brown
18. Mother's Name (First, Middle, Maiden Surname)
Willie Mae Anderson
19a. Informant's Name/Relationship (Type, Print) Wife
Audrey M. Hopkins-Brown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2657 Purnell Drive, Baltimore, Md 21207
20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Vet. 2/13/07
20c. Location - City or Town, State
Owings Mills, Md
21. Signature of Funeral Service Licensee
► Lynette K. Jones
22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. HYPO TENSION, SEPSIS
Due to (or as a consequence of):
c. PNEUMONIA, UROSEPSIS
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
UNKNOWN
UNKNOWN
UNKNOWN
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, CONGESTIVE HEART FAILURE,
STROKE, END STAGE RENAL DISEASE, CORONARY
ARTERY DISEASE, DEMENTIA
23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown
23d. Date of delivery
Month Day Year
23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed?
1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No
25. Was case referred to medical examiner?
1 Yes 2 No
26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 7 Homicide
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
N
29c. License number
P20661
29d. Date signed (Month, Day, Year)
February, 09, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAMUEL NOKURI 900 CATON AVE BALTIMORE, MD 21229
31. Date filed (Month, Day, Year)
FEB 13 2007
32. Registrar's Signature
▶ Anna B. Bell
ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important! If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

HOWARD BROWN

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important! If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 04 10

Certificate of Death

Reg No.

1- For State
RegistrarPhysician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) William M. Boston				2. Date of Death Month February Day 11 Year 2007	3. Time of Death 1518 hrs	
4a. Facility Name (if not institution, give street and number) 3106 Royston Avenue			4b. City, Town, or Location of Death Baltimore			
4c. County of Death N/A						
5. Social Security Number 213-46-1432	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) OCT 13 1946	9. Birthplace (State or Foreign Country) MD
10a. State MD			10b. County N/A			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 3106 Royston Avenue			10f. Zip Code 21214			10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automotive Sales			16b. Kind of Business/Industry Automotive
17. Father's Name (First, Middle, Last) James M. Boston				18. Mother's Name (First, Middle, Maiden Surname) Verna P. Penix		
19a. Informant's Name/Relationship (Type, Print) Doris Handley - sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17074 Big Falls Road, Monkton, MD 21111			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 2/13/2007	20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):						
b. _____ Due to (or as a consequence of):						
c. _____ Due to (or as a consequence of):						
d. _____						
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month _____ Day _____ Year _____	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other Scene				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier: <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 12, 2007
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 				

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

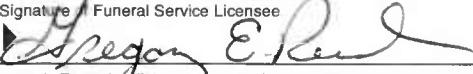
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 108

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
	Czeslawa L. Binko				February 7, 2007	7:10 P M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death
	Stella Maris Hospice Ctr.			Timonium		Baltimore Co.
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	217-09-0841	86			June 23, 1920	Maryland
Usual Residence of Decedent		10a. State Maryland				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10b. County Baltimore		10c. City, Town or Location Perry Hall		
10e. Street and Number 4229 Silver Spring Road			10f. Zip Code 21128		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 Years			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Awning Manufacturing
17. Father's Name (First, Middle, Last) Michael Nawrocki				18. Mother's Name (First, Middle, Maiden Surname) Bessie Mackowiak		
19a. Informant's Name/Relationship (Type, Print) Joseph Binko, Sr. (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4229 Silver Spring Road Perry Hall, Maryland 21128			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Mary Cem.		Date 2/10/2007	20c. Location - City or Town, State Dundalk, Maryland
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		
<p>23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to Immediate Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): End Stage Dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number DU3725				29d. Date signed (Month, Day, Year) February 08, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tariq Mahmood, M.D. 2300 Dulaney Valley Road, Timonium, MD 21093						
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 				

7:10 P.M.

February 07, 2007

Binko, Czeslawa, Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Within 24 hours after death.
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 109

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAURA BIERLY							2. Date of Death Month Day Year FEB 9 2007	3. Time of Death 20:53 M	
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A		
Funeral Director	5. Social Security Number 206-24-4187	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Mar 7, 1921	9. Birthplace (State or Foreign Country) Pennsylvania			
	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore County				10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 8710 Emge Road				10f. Zip Code 21234		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW2		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Registered Nurse		16b. Kind of Business/Industry Medical Services					
	17. Father's Name (First, Middle, Last) Robert Phillip Williams				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Jane Shawver					
	19a. Informant's Name/Relationship (Type, Print) Jacqueline J. Koliais (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14213 Sawmill Court, Phoenix, MD 21131					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Martin D. Lawson		20b. Place of Disposition (Name of cemetery, crematory or other place) Bee Tree Cemetery		Date 2/12/2007	20c. Location - City or Town, State Parkton, Maryland				
	21. Signature of Funeral Service Licensee Martin D. Lawson				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. COMPLETE LEFT LUNG ATELECTASIS Due to (or as a consequence of):</p> <p>b. Mucus PLUGGING Due to (or as a consequence of):</p> <p>c. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):</p> <p>d.</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINARY TRACT INFECTION, CHRONIC CHOLECYSTITIS								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier R. Z. MD		29c. License number RES-000				29d. Date signed (Month, Day, Year) FEB 10, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WYEL HAKIM 5601 LOCAL RAVEN BLVD BALTIMORE, MD 21239									
	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature John B. Jacobs							

Division of Vital Records, P.O. Box 68760,

Bierly, Laura 206244187

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 10

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SELMA BARNSTEIN				2. Date of Death Month Day Year FEBRUARY 10, 2007		3. Time of Death 11:03 AM		
	4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME		4b. City, Town, or Location of Death BALTIMORE			4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 217-05-4046	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min. 01/08/1917	If Under 24 Hrs. Hours Min. 01/08/1917	8. Date of Birth (Month, Day, Year) 01/08/1917	9. Birthplace (State or Foreign Country) MD		
	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No X	
To Be Completed by Funeral Director	10e. Street and Number 1 POMONA EAST #209			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: X		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: X		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MEDICAL SECRETARY			16b. Kind of Business/Industry MEDICAL			
	17. Father's Name (First, Middle, Last) MORRIS WOHL			18. Mother's Name (First, Middle, Maiden Surname) LENA BERGER					
	19a. Informant's Name/Relationship (Type, Print) LEE BARNSTEIN / SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 BRIDLEWOOD CT - OWINGS MILLS, MD 21117					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) X			20b. Place of Disposition (Name of cemetery, crematory or other place) MOSES MONTEFIORE CEM		Date 02/12/2007	20c. Location - City or Town, State HALETHORPE, MD		
	21. Signature of Funeral Service Licensee Jay Allen			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cervicogenicopathy							Approximate Interval Between Onset and Death Unknown	
	23b. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {								
	a. Due to (or as a consequence of): Cervicogenicopathy								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Demenia							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Alex J. Lehman		29c. License number DR 7569		29d. Date signed (Month, Day, Year) 2/10/07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alex J. Lehman 1838 Greene Tree Rd 21208								
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Leah B. Smith						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04111

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barry M Cuffia				2. Date of Death Month 2 Day 8 Year 07				3. Time of Death 1010AM	
	4a. Facility Name (If not institution, give street and number) Baltimore VA Medical Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-46-7094	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 07-06-1945	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	10a. State MD				10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 4917 Poe Avenue				10f. Zip Code 21215				10g. Citizen of What Country? U.S.A	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1968		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 year		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) Mail Carrier		16b. Kind of Business/Industry U.S. Post Office					
	17. Father's Name (First, Middle, Last) Allen Cuffia				18. Mother's Name (First, Middle, Maiden Surname) Arlean Pope					
	19a. Informant's Name/Relationship (Type, Print) Elsalencia Monroe / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4917 Poe Avenue, Baltimore, MD 21215					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus		20c. Location - City or Town, State 02-16-2007 Baltimore, MD					
	21. Signature of Funeral Service Licensee Vaughn C. Greene				22. Name and Address of Facility Vaughn C. Greene funeral service 8728 Liberty Road, Randallstown MD 21133					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hemorrhagic shock Approximate Interval Between Onset and Death									
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown									
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown									
	23d. Date of delivery Month Day Year									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure, cardiomyopathy, chronic deep venous thrombosis									
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide									
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	28d. Describe how injury occurred									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of Certifier A. Pratt, MD									
	29c. License number RES 0000									
	29d. Date signed (Month, Day, Year) 2/8/07									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Pratt, MD									
	31. Date filed (Month, Day, Year) FEB 13 2007									
	32. Registrar's Signature James M. Parker									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 112

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Louise Carroll							2. Date of Death Month Day Year Feb. 10, 2007	3. Time of Death 3:30 A.M.		
	4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore County				
Funeral Director	5. Social Security Number 218-32-9925		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 09, 1936	9. Birthplace (State or Foreign Country) Port Orange, Fla.			
	Usual Residence of Decedent		10a. State Maryland			10b. County Baltimore County			10c. City, Town or Location Towson	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1203 Providence Road				10f. Zip Code 21286		10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 01 Home Maker		16b. Kind of Business/Industry Own Home						
	17. Father's Name (First, Middle, Last) Earl Ward Rankin				18. Mother's Name (First, Middle, Maiden Surname) Merium Myrtle Plantz						
	19a. Informant's Name/Relationship (Type, Print) Ms. Debra J. Hitt (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 955 Beaver Bank Circle Towson, Maryland 21286						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel			Date 2/13/07	20c. Location - City or Town, State Forest Hill, Maryland				
	21. Signature of Funeral Service Licensee Jerry F. Givens		22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC LUNG DISEASE								Approximate Interval Between Onset and Death years		
	23b. Part II. Enter underlying causes contributing to death but not resulting in the underlying cause given in Part I. Arterosclerotic cardiovascular disease										
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier Kendall R Faulkner MD		29c. License number D25643			29d. Date signed (Month, Day, Year) 02/10/2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kendall R Faulkner MD 555 W. Towson Blvd/Baltimore 21204										
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Jerry F. Givens								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 11 3

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathleen M. Crusse							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 9:30 A M
	4a. Facility Name (If not institution, give street and number) Lighthouse Senior Living			4b. City, Town, or Location of Death Essex			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 429-05-0892		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) June 2, 1916	9. Birthplace (State or Foreign Country) Little Rock. AR.		
	Usual Residence of Decedent 10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1813 Old Eastern Avenue			10f. Zip Code 21221			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: White
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Clerical		
	17. Father's Name (First, Middle, Last) Edward W. Moore			18. Mother's Name (First, Middle, Maiden Surname) Mettie Poe Moore			19a. Informant's Name/Relationship (Type. Print) Edward Crusse Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 Old Eastern Avenue, Essex, MD. 21221
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Gardens Of Faith Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens Of Faith Cemetery			Date February 13, 2007	20c. Location - City or Town, State Rosedale, MD.	
	21. Signature of Funeral Service Licensee Anthony Connelly			22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Soller Point Road, Dundalk, Md. 21222			Approximate Interval Between Onset and Death 8 years.		
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Ali Sanai MD 29c. License number D44793 29d. Date signed (Month, Day, Year) 2/12/07									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Sanai 6730 Holabird Ave Balt, MD 21222									
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature James B. Foster							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit envelope.

Certificate of Death

Reg. No. 2007

3-Time of Death

1- For State Registrar

Physician /Medical Examiner

Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			Crusse				2. Date of Death Month Day Year	3-Time of Death	
William			Dundalk				February 12, 2007	9:35 A ^M	
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death		
7407 School Lane			Dundalk				Baltimore		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-34-6216			68 Yrs.					August 15, 1938	Maryland

Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10a. State	10b. County	10c. City, Town or Location							
Maryland	Baltimore	Dundalk							

10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?		
7407 School Lane			21222				USA		

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
--	--	---	--	--	--	--	--	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler			16b. Kind of Business/Industry General Motors				
College (1-4or 5+)									

17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
Louis Crusse				Lillian Carter				

19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Robert Crusse Brother			7420 Holabird Avenue, Dundalk, Maryland 21222					

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
		Meadowridge Cemetery			February 15, 2007	Elkridge, Maryland		

21. Signature of Funeral Service Licensee Anthony Connelly		22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222						
---	--	---	--	--	--	--	--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)									
a. Due to (or as a consequence of):									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year		
--	--	---	--	--	--	--	--	---	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Philip M. Mitchell, MD Deputy						
--	--	--	--	--	--	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		29c. License number		29d. Date signed (Month, Day, Year)				
Philip M. Mitchell, MD 6 Trumble Hill Ct, Lutherville, Md 21093		D18667		February 12, 2007				

31. Date filed (Month, Day, Year)		32. Registrar's Signature						
FEB 13 2007		Peter S. Farber						

State Registrar

07-01100

Carol Lee Crawford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 15

1- For State
Registrar**Physician/
Medical Examiner****Funeral
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
Medical
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

509 Locksley Road

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married2 Married3 Widowed4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes2 No

If Yes, Give Year

or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes2 No

specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Edward

Crawford

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis

Smith

19a. Informant's Name/Relationship (Type, Print)

Edward Crawford (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6621 Weymouth Court Baltimore, Maryland 21212

20a. Method of Disposition

1 Burial2 Cremation3 Removal from State4 Donation5 Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

2/12/07

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensed

Robert Kraut

22. Name and Address of Facility

Mitchell-Wiedefeld F.H. Inc.

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Atherosclerotic cardiovascular disease complicated by hypothermia*

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

#23a, PII, 27, 28a-f, per ME, g865, 3/1/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)9 Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA Other 4 Nursing Home 5 Residence 6 Other Scene

27. Manner of Death

1 Natural5 Pending investigation2 Accident6 Could not be determined3 Suicide7 Homicide

28a. Date of Injury (Month, Day, Year)

Fnd 2/9/2007

28b. Time of Injury

Fnd 10:05 am

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

subject exposed to cold

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

509 Locksley Rd.

Towson, MD

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ling Li, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 10, 2007

30.

Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31.

Date filed (Month, Day, Year)

FEB 13 2007

32. Registrar's Signature

Steve K. Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04116

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death	
	James Louis Downs							Month Day Year February 8 2007 826 AM				
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death				
	BALTIMORE WASHINGTON MEDICAL CENTER			GIEN BURNIE				AA COUNTY				
	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)				
	408-20-6417		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	89 Yrs.	Months	Days	Hours	Min.	May 21, 1917	Tennessee		
	Usual Residence of Decedent		10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits		
	Maryland Anne Arundel		Odenton							1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?				
	2509 Amber Orchard Court W #204				21113			United States				
	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
	1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White				
	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
	Elementary/Secondary (0-12)		College (1-4 or 5+)		1 Senior Engineering Specialist			National Security Agency				
	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)							
	John Q Downs				Minnie Taylor							
	19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
	Eleanor E. Downs/wife				2509 Amber Orchard Court W #204 Odenton, MD 21113							
	20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State					
	1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Ft. Lincoln Cemetery		2/12/2007		Bladensburg, Maryland					
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility							
	<i>Quanta R Thomas</i>				Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	<i>Pale myocardial infarction</i>											
	Approximate Interval Between Onset and Death											
	Immediate Cause (Final disease or condition resulting in death)											
	a. Due to (or as a consequence of):											
	<i>Coronary Artery Disease</i>											
	b. Due to (or as a consequence of):											
	c. Due to (or as a consequence of):											
	d. Due to (or as a consequence of):											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
	<i>Chronic Pulmonary obstructive Disease</i>											
	23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
			29c. Signature and title of certifier <i>K. Ambalavancar</i>									
			29d. License number D 51596									
			29d. Date signed (Month, Day, Year) February 8 th 2007									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		K. Ambalavancar 7845 Oakwood Road 103, Glen Burnie MD 21061									
	31. Date filed (Month, Day, Year)		32. Registrar's Signature <i>James Louis Downs</i>									
	FEB 13 2007											

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 11

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Louise Davidson						2. Date of Death Month Feb. Day 11 , Year 2007		3. Time of Death 4:13 AM		
		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death Maryland		
Funeral Director		5. Social Security Number 579-14-0939	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months 03	If Under 24 Hrs. Hours 31	Min. 14	8. Date of Birth (Month, Day, Year) 03/31/1914	9. Birthplace (State or Foreign Country) MS			
		10a. State MD		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 833 W. Pratt St. Apt. 301				10f. Zip Code 21201		10g. Citizen of What Country? USA				
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc. Specify: Black				
		15. Decedent's Education (Specify only highest grade completed) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry						
		17. Father's Name (First, Middle, Last) William J. Vancey		18. Mother's Name (First, Middle, Maiden Surname) Virginia Vancey								
		19a. Informant's Name/Relationship (Type, Print) Charles Vancey nephew		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9103 Adelphi Rd. Adelphi, MD 20783								
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Arbutus Cemetery Feb. 16, 2007 Baltimore, MD		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Cemetery		Date Feb. 16, 2007	20c. Location - City or Town, State Baltimore, MD					
		21. Signature of Funeral Service Licensee Vaughn C. Greene		22. Name and Address of Facility Vaughn C. Greene Funeral Services 5151 Baltimore Nat'l Pike Balt., MD 21229								
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End stage kidney disease						Approximate Interval Between Onset and Death				
		b. Diabetes mellitus Due to (or as a consequence of):										
		c. Hypertension Due to (or as a consequence of):										
		d.										
		IF FEMALE:		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown						23d. Date of delivery Month Day Year		
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
				M								
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Medical Examiner		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of certifier Lethia J. Weight, MD		29c. License number AT 2438946		29d. Date signed (Month, Day, Year) Feb. 11, 2007						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lethia J. Weight, MD, Union Memorial Hospital, Baltimore, MD										
		31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Lethia J. Weight								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 118

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) ANTONIO				2. Date of Death Month 02 Day 04 Year 2007		3. Time of Death 05:38 pM		
		4a. Facility Name (If not institution, give street and number) 3817 Fleetwood Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director		5. Social Security Number 212-30-5974	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 06/13/1917		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County N/A				10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		10e. Street and Number 3817 Fleetwood Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef		16b. Kind of Business/Industry Restaurant				
		17. Father's Name (First, Middle, Last) Luigi DiPasquale				18. Mother's Name (First, Middle, Maiden Surname) Maria Caccamo				
		19a. Informant's Name/Relationship (Type, Print) Anna Walega, Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13817 Jarrettsville Pike, Phoenix, MD 21131					
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 02/08/2007	20c. Location - City or Town, State Baltimore, Maryland		
		21. Signature of Funeral Service Licensee Alexandria Bates				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214				
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 7 mon
Medical Certification: To Be Completed by Physician/Medical Examiner		<p>a. Metastatic Lung Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) _____	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) _____				28f. Location (Street and Number or Rural Route Number, City or Town, State) _____		
		29b. Signature and title of certifier Charles Padgett, MD		29c. License number 015546				29d. Date signed (Month, Day, Year) Feb 5 2007		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Padgett, MD, 5601 Loch Raven Blvd, Baltimore, MD 21239								
State Registrar		31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature James B. Miller						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 19

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH DEVAUD							2. Date of Death Month Day Year 02 08 2007	3. Time of Death 3:55 A M
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-20-6464	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months 02	If Under 24 Hrs. Days 08	8. Date of Birth (Month, Day, Year) 11-05-1925	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	10e. Street and Number 2702 Southern Avenue			10f. Zip Code 21214			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White			14. Race - American Indian, Black, White, etc.	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant			16b. Kind of Business/Industry Insurance		
	17. Father's Name (First, Middle, Last) John H. Goldbeck					18. Mother's Name (First, Middle, Maiden Surname) Mary Goldbeck			
	19a. Informant's Name/Relationship (Type, Print) Charles H. Devaud, Sr.-Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2702 Southern Avenue Baltimore, MD 21214			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Charles J. Morris Jr.			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.		Date 02/12/2007	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee Charles J. Morris Jr.			22. Name and Address of Facility Leonard J. Ruck, Inc.			5305 Harford Road Baltimore, MD 21214		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemorrhagic Stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coagulopathy Due to (or as a consequence of): Atrial fibrillation Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Dyslipidemia								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number RES. 000			29d. Date signed (Month, Day, Year) 02/08/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEI CHI, 5601 LOCH RAVEN BLVD, Baltimore, MD 21239								
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature James B. Spangler						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 120

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	DUKE			2. Date of Death Month Day Year	3. Time of Death
JOSEPH O.				02 09 07	15 13 M

4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death
ANNAPOLIS

4c. County of Death
ANNE ARUNDEL

Funeral
Director

5. Social Security Number 177-18-6548	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 13, 1922	9. Birthplace (State or Foreign Country) PENNSYLVANIA
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To Be Completed by Funeral Director

Usual Residence of Decedent
10a. State
MARYLAND
10b. County
ANNE ARUNDEL
10c. City, Town or Location
PASADENA
10e. Street and Number
8177 SOLLEY RD.
10f. Zip Code
21122
10g. Citizen of What Country?
UNITED STATES

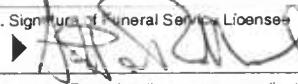
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST	16b. Kind of Business/Industry BUILDING
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17. Father's Name (First, Middle, Last) WILLIAM HENRY DUKE	18. Mother's Name (First, Middle, Maiden Surname) ELSIE BELLE GARN
---	---

19a. Informant's Name/Relationship (Type, Print) JUDY WILLIAMS / NIECE	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8343 DOCK RD., PASADENA, MARYLAND 21122
---	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PARK	Date FEBRUARY	20c. Location - City or Town, State GLEN BURNIE, MARYLAND
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Due to (or as a consequence of): <i>End Stage Renal Disease</i>	Approximate Interval Between Onset and Death <i>year</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): <i>by peritonitis</i>	<i>year</i>
c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

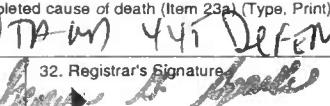
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Patient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D 21438
--	--------------------------------

29b. Signature and title of certifier 	29d. Date signed (Month, Day, Year) Feb 11, 2007
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL J. LARSEN TA #441 DEFENSE HIGHWAY ANNAPOLIS MD 21401	32. Registrar's Signature 
--	--

31. Date filed (Month, Day, Year) FEB 13 2007
--

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04121

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Woodrow G. Europa</i>							2. Date of Death Month 02 Day 10 Year 07	3. Time of Death unknown
	4a. Facility Name (If not institution, give street and number) <i>8943 Harkate Way</i>			4b. City, Town, or Location of Death <i>Randallstown, MD</i>			4c. County of Death <i>Baltimore County</i>		
Funeral Director	5. Social Security Number <i>085-50-1184</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>49</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>03-24-1957</i>	9. Birthplace (State or Foreign Country) <i>New York</i>	
	Usual Residence of Decedent <i>MD Baltimore</i>		10c. City, Town or Location <i>Randallstown</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <i>8943 Harkate Way</i>			10f. Zip Code <i>21133</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>If Yes, Give Year or Dates:</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Filipino</i>		14. Race - American Indian, Black, White, etc. Specify: <i>Filipino</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Electrical Engineer</i>			16b. Kind of Business/Industry <i>Northrop Grumman</i>		
	17. Father's Name (First, Middle, Last) <i>Feliciano Europa</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Philadelphia Guzman</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Michelle Europa / Wife</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8943 Harkate Way, Randallstown MD 21133</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Vaughn C. Greene</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmant Crematory</i>		Date <i>02-13-2007</i>	20c. Location - City or Town, State <i>Baltimore, MD</i>		
	21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>			22. Name and Address of Facility Vaughn C. Greene Funeral Service <i>8728 Liberty Road Randallstown</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Hypertensive Cardiomyopathy</i> Due to (or as a consequence of): <i>CHF</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>noncompliance with medical therapy</i> Due to (or as a consequence of): <i>d.</i>								Approximate Interval Between Onset and Death <i>2003-2007</i> <i>4 years</i>
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Kimberly Baydarian MD</i>						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Randallstown MD 21133</i>			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <i>D0061684</i>			29d. Date signed (Month, Day, Year) <i>2/12/07</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kimberly Baydarian MD 8507 Liberty Road Randallstown MD 21133</i>			32. Registrar's Signature <i>Susan B. Aponte</i>			31. Date filed (Month, Day, Year) <i>FEB 13 2007</i>		

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

07-01131

Dwight L. Evans

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 122

1- For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	Dwight Gerell Evans				2. Date of Death	3. Time of Death	
DWIGHT L. EVANS				Month	Day	Year	1838 hrs
				February 10, 2007			

**Funeral
Director**

4a. Facility Name (if not institution, give street and number)	Johns Hopkins Hospital				4b. City, Town, or Location of Death	Baltimore		4c. County of Death
								N/A
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)		
214 86 8884	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	32 Yrs.	Months	Days	FEB. 4, 1975	MD.		

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2433 E. MADISON ST.	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12) GED	College (1-4 or 5+) ENTREPRENEUR	SELF EMPLOYED

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JEROME EVANS	EVELYN BOYD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JEROME EVANS /father	2313 E. MADISON ST. BALTO, MD. 21205

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	TRINITY CEMETERY	FEB. 16, 2007	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
<i>Bernadine J. Evans</i>	CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wounds (2) of Head and Torso
	Due to (or as a consequence of):
	b. Due to (or as a consequence of):
	c. Due to (or as a consequence of):
	d. Due to (or as a consequence of):

<input type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED	#1. PERME. 864, 2/16/07 TT	23d. Date of delivery
IF FEMALE:	23c. If yes, outcome of pregnancy	Month	Day
23b. Was decedent pregnant in the past 12 months?	1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	Year	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed?
	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide	Feb 10, 2007	1821 hrs	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Subject shot
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	Store front	2429 East Madison Street, Baltimore, MD		

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	<i>Patricia Aronica-Pollak</i>	O.C.M.E.	February 11, 2007

30. Name and address of person who completed cause of death (Item 23a)	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
--	---

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FFB 13 2007	<i>Leanne B. Pollak</i>

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certificate.

**Physician/
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certificate.

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 123

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth E. Ebersole

2. Date of Death

Month

Day

Year

3. Time of Death

3:00 P.M.

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

2. Date of Death

Month

Day

Year

3. Time of Death

3:00 P.M.

5. Social Security Number

218-26-8222

6. Sex

M F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

October 7, 1925

9. Time of Death

3:00 P.M.

4c. County of Death

Anne Arundel

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

Yes No

10e. Street and Number

513 Norwich Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No WWII
 Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Union Vending

17. Father's Name (First, Middle, Last)

Melvin Ebersole

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Pauline Grandel

19a. Informant's Name/Relationship (Type, Print)

Robert K. Ebersole/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2319 Cool Woods Court Jarrettsville, MD 21084

Date

20c. Location - City or Town, State

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

Towson Maryland

21. Signature of Funeral Service Licensee

Christie L. Hilton

22. Name and Address of Facility

Leopard J. Ruck, Inc.
5305 Hartford Road Baltimore Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

2 years
week.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
Pulmonary fibrosis

b. Due to (or as a consequence of):
Pneumonia

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital: Inpatient ER/Outpatient DOA

Other: Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

M

1 Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶

MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

February 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

▶
Angela D. Ebersole - 301 Hazelwood Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

FEB 19 2007

32. Registrar's Signature

▶

KENNETH EBERSOLE
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,
Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 121

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Egglesston, Joseph
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) JOSEPH WILLIAM EGGLESTON, JR.				2. Date of Death Month Day Year February 10 2007				3. Time of Death 7:40p M			
4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE			
5. Social Security Number 219-18-1055		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) Jan 23, 1926		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent Maryland Baltimore County				10c. City, Town or Location Towson				10d. Inside City Limits 1 Yes 2 No			
10e. Street and Number One Southerly Court, Unit 303				10f. Zip Code 21286				10g. Citizen of What Country? USA			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Mechanical Contractor		16c. Kind of Business/Industry Construction					
17. Father's Name (First, Middle, Last) Joseph William Eggleston				18. Mother's Name (First, Middle, Maiden Surname) Esther Jones							
19a. Informant's Name/Relationship (Type, Print) Mrs. Georgetta U. Eggleston				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) One Southerly Court, Unit 303, Towson, MD 21286							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		Date 2/13/2007		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Person Robert M. Kratz				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE										Years	
b. Due to (or as a consequence of): CORONARY ARTERY DISEASE - MI										Years	
c. Due to (or as a consequence of): VALVULAR HEART DISEASE										Years	
d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure										23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Alan Kimmel									
		29c. License number D25783				29d. Date signed (Month, Day, Year) 2/12/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Kimmel, MD, 6569 North Charles St. Towson, MD 21204											
31. Date filed (Month, Day, Year) FEB 13 2007											
32. Registrar's Signature [Signature]											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 125

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jacob Ferguson							2. Date of Death Month Day Year Feb. 9, 2007	3. Time of Death 7:50 A M											
	4a. Facility Name (If not institution, give street and number) Frederick Villa Nursing Home			4b. City, Town, or Location of Death Catonsville			4c. County of Death													
Funeral Director	5. Social Security Number 237-28-7698		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 7, 1918		9. Birthplace (State or Foreign Country) North Carolina												
	10a. State MD		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
To Be Completed by Funeral Director	10e. Street and Number 5209 Hillwell Road			10f. Zip Code 21229			10g. Citizen of What Country? USA													
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Truck Driver		16b. Kind of Business/Industry AM Castle															
	17. Father's Name (First, Middle, Last) Ransom Ferguson					18. Mother's Name (First, Middle, Maiden Surname) Malisse McNeal														
	19a. Informant's Name/Relationship (Type, Print) Alvera Jones Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5209 Hillwell Rd. Baltimore, MD 21229			Date		20c. Location - City or Town, State Feb. 15, 2007 Owings Mills, MD												
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Garrison Forest		20b. Place of Disposition (Name of cemetery, crematory or other place)																	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Vaughn C. Green					22. Name and Address of Facility Vaughn C. Green Funeral Services 5151 Baltimore Nat'l Pike Baltimore, MD 21229														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																			
	<p>a. Due to (or as a consequence of): FAILURE TO THRIVE</p> <p>b. Due to (or as a consequence of): ADVANCED DEMENTIA</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>																			
	Approximate Interval Between Onset and Death																			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LEFT HIP REPLACEMENT										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred								
	<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					M														
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)														
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
	29b. Signature and title of certifier R Fernando Attending					29c. License number D0090303					29d. Date signed (Month, Day, Year) 02/12/07									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodolfo Fernandez MD 516 N Rolling Rd Apt 205 21228																			
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007			32. Registrar's Signature Debra L. Foster																

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 126

1- For State
Registrar**Physician/
Medical Examiner****Funeral
Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/
Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		GAITHER		2. Date of Death Month Day Year February 8, 2007	3. Time of Death 2130 hrs
DARNELL					
4a. Facility Name (if not institution, give street and number) John Hopkins		4b. City, Town, or Location of Death Baltimore		4c. County of Death NIA	
5. Social Security Number 216-86-2262	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) JULY 03, 1972	
Usual Residence of Decedent MARYLAND NIA		10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4021 EDGEWOOD ROAD		10f. Zip Code 21215		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) I YR.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COACH		16b. Kind of Business/Industry SELF-EMPLOYED	
17. Father's Name (First, Middle, Last) CLEMENT P. GAITHER		18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY L. BARNES			
19a. Informant's Name/Relationship (Type, Print) DENISE DRAKE (SISTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7478 CATTERICK CT., BALTIMORE, MD 21244			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify O'Dowd		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEME, 02-14-07		Date	20c. Location - City or Town, State BALTIMORE, MD.
21. Signature of Funeral Service Licensee O'Dowd		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2918 N. FULTON AVE., BALTO, MD 21217			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
a. Gunshot Wound of Torso Due to (or as a consequence of):					
b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____					
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) Feb 8, 2007		28b. Time of Injury 2042 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Subject shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4200 block of St. George, Baltimore, MD			
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier H. Brassell MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 9, 2007	
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201					
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Leanne B. Spangler			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04127

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James O. Greathouse, Jr.				2. Date of Death Month February Day 11 Year 2007		3. Time of Death 6:49 p M		
	4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice Care				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212-36-9510		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) JUL 31 1940	9. Birthplace (State or Foreign Country) WV	
	Usual Residence of Decedent MD Baltimore		10a. State MD 10b. County Baltimore		10c. City, Town or Location Essex			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 16 Clipper Road				10f. Zip Code 21221		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry HVAC Mechanic				
	17. Father's Name (First, Middle, Last) James O. Greathouse, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Esther Dyer				
	19a. Informant's Name/Relationship (Type, Print) Dawn M. Markey - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 836 Cottonwood Drive, Severna Park, MD 21146				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 2/12/2007	20c. Location - City or Town, State Baltimore, MD			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer								
	Approximate Interval Between Onset and Death months								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause								
	a. Due to (or as a consequence of): Lung Cancer								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown								
	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)								
	23d. Date of delivery Month Day Year								
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
	28a. Date of Injury (Month, Day Year) M								
	28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number D 58303								
	29d. Date signed (Month, Day, Year) February 12 2007								
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James O. Greathouse, Jr. 6701 N. Charles St. Baltimore MD 21207								
	31. Date filed (Month, Day, Year) FEB 13 2007								
	32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 06128

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VALORIE ANNA GERMAN							2. Date of Death Month FEBRUARY Day 9 Year 2007	3. Time of Death 11:50 A M
	4a. Facility Name (If not institution, give street and number) 2046 Lox Road			4b. City, Town, or Location of Death JARRETTVILLE			4c. County of Death HARFORD		
Funeral Director	5. Social Security Number 819-03-1845	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) AUG 9 1918	9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	10a. State MARYLAND 10b. County HARFORD 10c. City, Town or Location JARRETTVILLE							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2046 Lox Road			10f. Zip Code 21084			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 87-88		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE		14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL BUS DRIVER		16b. Kind of Business/Industry BALTIMORE COUNTY SCHOOLS				
	17. Father's Name (First, Middle, Last) ROBERT L. GRAY		18. Mother's Name (First, Middle, Maiden Surname) MARGARET B. FLINT						
	19a. Informant's Name/Relationship (Type, Print) TIMOTHY A. GERMAN, SR		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2046 Lox Road JARRETTVILLE, MARYLAND 21084		Date FEB. 16, 2007				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ROSEDALE MARYLAND		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDEN OF FAITH		20c. Location - City or Town, State ROSEDALE MARYLAND				
	21. Signature of Funeral Service Licensee DONALD P. GERMAN		22. Name and Address of Facility EVANS FUNERAL HOME AND CREMATION SERVICES 311 WOODSTICK DRIVE FORESTHILL MARYLAND 21050						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 2 years	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Linda A. Walsh MD		29c. License number D34208		29d. Date signed (Month, Day, Year) FEBRUARY 12, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. LINDA WALSH, MD. 3118 NORRISVILLE ROAD JARRETTVILLE, MARYLAND 21084								
	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature H. J. G.						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend #29d Per Phy G864 2713/07 JH
State Amend #29d Per Phy G864 2713/07 JH
Registrar Certificate of Death

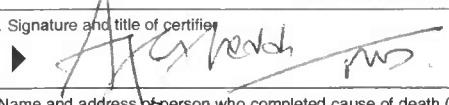
Reg. No.

2007

01/180

Time of Death

4:55 A M

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN GOLD							2. Date of Death Month Day Year FEBRUARY 8, 2007		3. Time of Death 4:55 A M				
	4a. Facility Name (If not institution, give street and number) BRIGHTON GARDENS			4b. City, Town, or Location of Death NORTH BETHESDA			4c. County of Death MONTGOMERY							
Funeral Director	5. Social Security Number 151-12-3700		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/11/1924		9. Birthplace (State or Foreign Country) NJ					
	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location NORTH BETHESDA				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 5550 TUCKERMAN LANE				10f. Zip Code 20852			10g. Citizen of What Country? USA						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COLLERK				16b. Kind of Business/Industry CLERICAL						
	17. Father's Name (First, Middle, Last) ABRAHAM				18. Mother's Name (First, Middle, Maiden Surname) KAPLAN MAY				SCHWARTZ					
	19a. Informant's Name/Relationship (Type, Print) ALLAN GOLD / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8709 GARFIELD STREET - BETHESDA, MD 20817									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) PASSAIC JUNCTION CEM.			Date 02/09/2007	20c. Location - City or Town, State SADDLE BROOK, NJ						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC.				8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal failure										Approximate Interval Between Onset and Death			
	a. Due to (or as a consequence of) Congestive Heart failure													
	b. Due to (or as a consequence of) Chronic obstructive pulmonary disease.													
	c. Due to (or as a consequence of) Hypertension													
	d. (Handwritten note: "Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last")													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia. Peripheral vascular disease.										23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29d. Date signed (Month, Day, Year) Feb 8, 2007 February 08, 2007			
	29b. Signature and title of certifier 										29c. License number D53691			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amy Kenny ms 6320 Democracy Blvd, Bethesda MD 20877													
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Amend #10e, 19b, per Fr, G864, 2/16/07 TT
Registrar State of Maryland / Department of Health and Mental Hygiene
Certificate of Death Reg. No. 2007 04131

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Francis Herr</i>						2. Date of Death Month Day Year <i>FEBRUARY 8, 2007</i>		3. Time of Death <i>11:45 AM</i>		
Funeral Director		4a. Facility Name (If not institution, give street and number) <i>St. Joseph's Medical Center</i>			4b. City, Town, or Location of Death <i>TOWSON</i>			4c. County of Death <i>Baltimore</i>				
To Be Completed by Funeral Director		5. Social Security Number <i>216-34-2557</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. /last birthday) <i>69 Yrs.</i>	If Under 1 Year Months <i> </i>	If Under 24 Hrs. Days <i> </i>	8. Date of Birth (Month, Day, Year) <i>Feb. 9, 1937</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>				
		Usual Residence of Decedent 10a. State <i>MD</i>						10b. County <i>Baltimore</i>			10c. City, Town or Location <i>Carney</i>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number <i>3026 Third Avenue</i>			10f. Zip Code <i>21234</i>			10g. Citizen of What Country? <i>USA</i>				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i> </i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i> </i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Security Officer</i>			16b. Kind of Business/Industry <i>Maryland Rehabilitation Center</i>					
		17. Father's Name (First, Middle, Last) <i>Joseph Herr</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Helen V. Martel</i>							
		19a. Informant's Name/Relationship (Type, Print) <i>M. Patricia Herr-spouse</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3026 Third Avenue-Carney, Maryland 21234</i>							
Physician /Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Conradie L M. Fadden</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parkwood Cemetery</i>	Date <i>2-12-07</i>	20c. Location - City or Town, State <i>Parkville, Maryland</i>							
Medical Certification: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <i>Conradie L M. Fadden</i>			22. Name and Address of Facility <i>EVANS FUNERAL CHAPEL AND CREMATION SERVICES</i>			8800 Harford Road Parkville, MD 21234				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>ASPIRATION ANEMIA</i>						Approximate Interval Between Onset and Death <i>1 week</i>				
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>DYSPHAGIA</i>										
		a. Due to (or as a consequence of): <i> </i>										
		b. Due to (or as a consequence of): <i> </i>										
		c. Due to (or as a consequence of): <i> </i>										
		d. Due to (or as a consequence of): <i> </i>										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i> </i>			23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Obstetric complications</i> <i>Arterial fibrillation</i> <i>History of cerebral hemorrhage</i>			26. Place of Death (Check only one) <i>Inpatient</i>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i> </i>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <i> </i>							
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <i>31189</i>			29d. Date signed (Month, Day, Year) <i>February 8, 2007</i>				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael J. Minnifield, M.D.</i>			32. Registrar's Signature <i>Asst. H. Jones</i>							
State Registrar		31. Date filed (Month, Day, Year) <i>FEB 13 2007</i>			32. Registrar's Signature <i>Asst. H. Jones</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 132

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Annie Hawkins</i>							2. Date of Death Month Day Year <i>Feb. 5, 2007</i>	3. Time of Death 11:00 AM
	4a. Facility Name (If not institution, give street and number) <i>Rockglen Nursing Home</i>				4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>NC</i>	
Funeral Director	5. Social Security Number <i>245-56-1333</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year <i>Nov. 23, 1929</i>	9. Birthplace (State or Foreign Country) <i>NC</i>	
	Usual Residence of Decedent To Be Completed by Funeral Director		10a. State <i>MD</i>	10b. County	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>4617 Rokeby Road</i>					10f. Zip Code <i>21229</i>	10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) <i>12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nurses Assistant</i>			16b. Kind of Business/Industry <i>Health Care</i>				
17. Father's Name (First, Middle, Last) <i>Linwood Robinson</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Rosa Jones</i>			19a. Informant's Name/Relationship (Type, Print) <i>Andre Hawkins (Son)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5674 Leiden Rd., Balto., MD 21206</i>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Garrison Forest</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest</i>			Date <i>2/12/07</i>	20c. Location - City or Town, State <i>Owings Mills, MD</i>			
21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>		22. Name and Address of Facility <i>Vaughn C. Greene Funeral Services 5151 Balto. Nati'l Pike Baltimore, MD 21229</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Coronary Artery Disease</i>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Gangrene Foot</i>			Approximate Interval Between Onset and Death				
23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>		23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				
28a. Date of Injury (Month, Day Year) <i>2/12/07</i>		28b. Time of Injury M <i>1</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore, MD 21229</i>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>D511418</i>			29d. Date signed (Month, Day, Year) <i>February 9/2007</i>				
29b. Signature and title of certifier <i>M. Lawrence</i>		29c. License number <i>D511418</i>			29d. Date signed (Month, Day, Year) <i>February 9/2007</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mike Lawrence 1501 W. Mt Royal Av Baltimore, MD 21217</i>		31. Date filed (Month, Day, Year) <i>FEB 13 2007</i>			32. Registrar's Signature <i>John B. Smith</i>				

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

62

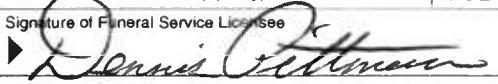
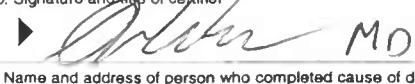
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 10b per MD 864 2-21-07

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 133
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Horne						2. Date of Death Month Day Year February 9 2007	3. Time of Death 8:20 P M	
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital			4b. City, Town, or Location of Death Columbia			4c. County of Death Howard		
Funeral Director	5. Social Security Number 231-84-5345	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 4, 1909	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent 10a. State Maryland						10d. Inside City Limits 1 Yes 2 No		
To Be Completed by Funeral Director	10b. County Baltimore	10c. City, Town or Location Baltimore						10g. Citizen of What Country? U.S.A.	
	10e. Street and Number 2016 Mars Run Road			10f. Zip Code 21221					
	11. Marital Status 3 Widowed	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Joseph Grasberger			18. Mother's Name (First, Middle, Maiden Surname) Mary Bliley					
	19a. Informant's Name/Relationship (Type, Print) Mary McAninch (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 785 Pleasant St., Highland Springs, VA 23075					
	20a. Method of Disposition 1 Burial			20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Lawn Cemetery	Date 2/14/07	20c. Location - City or Town, State Richmond, VA			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Joseph W. Bliley Co., Inc. P.O. Box 6267, Richmond, VA 23230					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia							Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
								24a. Was an autopsy performed? 1 Yes 2 No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
	25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred		
	5 Pending investigation 6 Could not be determined			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number 00063653					
	29b. Signature and title of certifier 			29d. Date signed (Month, Day, Year) February 9, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawn Evans 5755 Cedar Lane Columbia, Maryland 21044								
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 134

1- For
State
Registrar

Physician
/Medical
Examiner

Dennis H. Hook
Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of a fatality.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Dennis H. Hook
Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death							
DENNIS H. HOOK		FEBRUARY 7, 2007				12:29 P M							
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death							
BALTIMORE WASHINGTON MEDICAL CENTER		GLEN BURNIE				ANNE ARUNDEL							
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)						
220-56-7916			53			JULY 9, 1953	MARYLAND						
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10a. State	10b. County	10c. City, Town or Location											
MARYLAND	ANNE ARUNDEL	PASADENA											
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?							
30 KELLINGTON DRIVE		21122				UNITED STATES							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE							
Elementary/Secondary (0-12) 9		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry CONSTRUCTION							
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)									
CLARENCE H. HOOK				EVELYN A. MARKLEY									
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
CLARENCE HOOK / FATHER		30 KELLINGTON DR. PASADENA, MD 21122											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) ►		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date FEBRUARY 10, 2007	20c. Location - City or Town, State GLEN BURNIE, MARYLAND								
21. Signature of Funeral Service Licensee ►		22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. SE GLEN BURNIE, MD 21061											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Acute myocardial infarction Due to (or as a consequence of): Othosclerotic cardiovascular disease Due to (or as a consequence of): Cirrhosis						Approximate Interval Between Onset and Death immediate years					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. emphysema diabetes mellitus cirrhosis		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier ► Dale Kaplan M.D.		29c. License number D25611-Maryland		29d. Date signed (Month, Day, Year) 2/8/07									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRA E. KAPLAN, M.D., 7845 OAKWOOD RD., GLEN BURNIE, MARYLAND 21061													
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Dale Kaplan											

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 1 per dr., G864, 02/13/07/dhp
State of Maryland / Department of Health and Mental Hygiene,
Certificate of Death

2007 04/135
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEVERLY A HOOSIN Beverly Hoosin												2. Date of Death Month 01 Day 03 Year 07	3. Time of Death 4:05 pm
Funeral Director	4a. Facility Name (If not institution, give street and number) BEL PRE HEALTH & REHAB												4b. City, Town, or Location of Death BLAVER SPRING	4c. County of Death HHD
To Be Completed by Funeral Director	5. Social Security Number 218-78-8435		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) June 6, 1956	9. Birthplace (State or Foreign Country) Washington DC						
Usual Residence of Decedent	10a. State MD	10b. County Prince George's	10c. City, Town or Location Oxon Hill								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 46178 Wheeler Hills Road				10f. Zip Code 20745				10g. Citizen of What Country? USA					
Physician /Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: None			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: black			14. Race - American Indian, Black, White, etc. Specify: black					
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0			16b. Kind of Business/Industry disabled			18. Mother's Name (First, Middle, Maiden Surname) Anne Cox					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	19a. Informant's Name/Relationship (Type, Print) Sadie Hammon/aunt		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6716 W. Forest Road #203 Landover, MD 20785			20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	a. Renal Failure Due to (or as a consequence of):													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	b. Respiratory Failure Due to (or as a consequence of):													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	c. Superior Vena Cava Syndrome Due to (or as a consequence of):													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit													24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 046584				29d. Date signed (Month, Day, Year) 1/4/07							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. MCNEIL 13975 Connecticut Ave #202 Silver Spring MD 20906		32. Registrar's Signature John McNeil											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	31. Date filed (Month, Day, Year) FEB 13 2007		33. Registrar's Signature John McNeil											

State Registrar

#1
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04136

1- For
State
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Kathy T. Jackson</i>				2. Date of Death Month February Day 11 Year 2007		3. Time of Death 10:45 PM	
	4a. Facility Name (If not institution, give street and number) <i>Future Care Caton Harbor</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>			
Funeral Director	5. Social Security Number <i>214-84-8602</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>45 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>Dec 22, 1961</i>	9. Birthplace (State or Foreign Country) <i>MO</i>	
	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>N/A</i> 10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <i>1538 Elrino Ave.</i>			10f. Zip Code <i>21224</i>		10g. Citizen of What Country? <i>United States</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>2000</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i></i>		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 9</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nurse Aide</i>		16b. Kind of Business/Industry <i>Hospital</i>				
	17. Father's Name (First, Middle, Last) <i>Benjamin Jackson</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Geraldine Moore</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Geraldine Jackson - Mother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>440 Boldon St Baltimore, MD 21224</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mount Zion Cem. Feb 17, 2007</i>		Date <i></i>	20c. Location - City or Town, State <i>Baltimore, MD</i>		
	21. Signature of Funeral Service Licensee <i>John D. Allen</i>				22. Name and Address of Facility <i>CALVIN L. WILLIAMS F.S., P.A., P.O. Box 11651, Baltimore, MD 21229</i>			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>AIDS</i>							
	Approximate Interval Between Onset and Death <i></i>							
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i></i>							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
	24a. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day, Year) <i>28b. Time of Injury M</i> 28c. Injury at Work? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i> 28d. Describe how injury occurred <i></i>							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i></i> 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i>							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i></i> 29c. License number <i>H0068638</i> 29d. Date signed (Month, Day, Year) <i>2/12/2007</i>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jonathan Rich, 2801 Hudson St., Suite A, Baltimore, MD 21234</i>							
	31. Date filed (Month, Day, Year) <i>FEB 13 2007</i> 32. Registrar's Signature <i></i>							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 137

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death			
	Rudolph Koltz				Month	Day	Year			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death				
	Harbor Hospital			Baltimore						
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)		
	219-05-1221		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	87 Yrs.	Months	Days	Hours	Min.	Aug. 16, 1919 MD	
	Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location		10d. Inside City Limits	
			MD		Anne Arundel		Linthicum		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?		
	22 Patapsco Road				21090			USA		
	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white	
	Elementary/Secondary (0-12)		College (1-4 or 5+)			15. Decedent's Education (Specify only highest grade completed) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Machinist	16b. Kind of Business/Industry American Can Com.
	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
	Rudolph R. Koltz Sr.					Clara Bryant				
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Cornelia M. Koltz - Wife				22 Patapsco Road Linthicum, MD 21090						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
				Metro Crematory			Feb. 12, 07	Baltimore, MD		
21. Signature of Funeral Service Licensee ► Kim MacLeod				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)								4/ years	
	a. End stage renal disease									
	Due to (or as a consequence of):									
	b. Multi organ failure									
	Due to (or as a consequence of):									
	c.									
	d.									
	IF FEMALE:		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year	
	23b. Was decedent pregnant in the past 12 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension COPD Atrial Fibrillation								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		M								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier ► Justin Rafael		29c. License number P20756						29d. Date signed (Month, Day, Year) February 10, 2007		
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature ▶ Justin B. Rafael								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

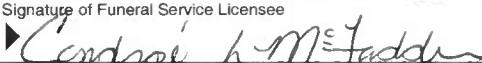
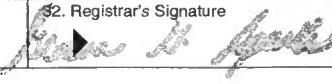
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 138

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Julius Kaufman					2. Date of Death Month Day Year FEBRUARY 8, 2007	3. Time of Death 03:40A M		
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 219-09-1399		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) March 26, 1920	9. Birthplace (State or Foreign Country) Maryland	
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 8625 Richmond Avenue			10f. Zip Code 21234			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Owner			16b. Kind of Business/Industry Carpet Corner		
	17. Father's Name (First, Middle, Last) Carl E. Kaufman					18. Mother's Name (First, Middle, Maiden Surname) Eva Mitzel			
	19a. Informant's Name/Relationship (Type, Print) Carl Jay Kaufman-son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Shorehaven Drive-Poinciana, Florida 34759			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		Date 2-17-07	20c. Location - City or Town, State Parkville, Maryland			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES		8800 Harford Rd. Parkville, MD 21234				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death			
	<p>a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CRITICAL AORTIC VALVE STENOSIS					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0017695			29d. Date signed (Month, Day, Year) February 8, 2007			
	29b. Signature and title of certifier 								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J HELOU, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204								
	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 139
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEONA KASTINA				2. Date of Death Month Day Year FEBRUARY 9 2007	3. Time of Death 10:20 AM	
	4a. Facility Name (If not institution, give street and number) 101 Center Place Apt 210		4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-09-7241	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) November 20, 1916	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State Maryland		10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 3625 Lyndale Avenue			10f. Zip Code 21213		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 8 years		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Bakery	
17. Father's Name (First, Middle, Last) Susan Kastina Stitz Daughter				18. Mother's Name (First, Middle, Maiden Surname) Mary Guzinski			
19a. Informant's Name/Relationship (Type, Print) Susan Kastina Stitz Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8521 High Ridge Road, Ellicott City, MD. 21043			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Anthony Connely		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.		Date February 12, 2007	20c. Location - City or Town, State Rosedale, Maryland		
21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A.				22. Name and Address of Facility 7110 sollers Point Road, Dundalk, MD. 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA							
Approximate Interval Between Onset and Death 3 YEARS							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA							
Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to compilation of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Jennifer Hayashi MD		29c. License number D62032		29d. Date signed (Month, Day, Year) FEBRUARY 9 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAYASHI, 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224							
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Alma B. Speller					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 U 140

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Steven Kisielewski						2. Date of Death Month 02	Day 10	Year 07	3. Time of Death 2:48 A M
		4a. Facility Name (If not institution, give street and number) University of Maryland Medical System						4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A
Funeral Director		5. Social Security Number 220-38-7701		6. Sex 1 XM 2 F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 27, 1941	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Sparrows Point				10d. Inside City Limits 1 Yes 2 No	
		10e. Street and Number 7319 Betz Avenue				10f. Zip Code 21219			10g. Citizen of What Country? USA		
		11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deli Manager		16b. Kind of Business/Industry Mars Supermarkets					
		17. Father's Name (First, Middle, Last) Alexander Kisielewski				18. Mother's Name (First, Middle, Maiden Surname) Helen Gaydosh					
		19a. Informant's Name/Relationship (Type, Print) Patricia Kisielewski wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7319 Betz Avenue, Sparrows Point, Maryland 21219					
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Of Jesus Cem.			Date February 15, 2007	20c. Location - City or Town, State Dundalk, Maryland			
		21. Signature of Funeral Service Licensee Anthony Connelly		22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
		Immediate Cause (Final disease or condition resulting in death) gastric mucormycosis									
		Due to (or as a consequence of):									
		b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last acute myocardial infarction									
		Due to (or as a consequence of):									
		c. gastrointestinal ischemia									
		Due to (or as a consequence of):									
		d.									
		Approximate Interval Between Onset and Death									
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.											
Medical Certification: To Be Completed by Physician/Medical Examiner											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
		23f. Date of delivery Month Day Year									
		24a. Was an autopsy performed? 1 Yes 2 No									
		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No									
		25. Was case referred to medical examiner? 1 Yes 2 No									
		26. Place of Death (Check only one) Hospital: i Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide									
		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No									
		28d. Describe how injury occurred									
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)									
		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier Tiffany Stoddard MD									
		29c. License number AV4176435 S21078									
		29d. Date signed (Month, Day, Year) 02/10/07									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tiffany Stoddard MD 22 South Greene Street, Baltimore MD 21201									
State Registrar		31. Date filed (Month, Day, Year) FEB 13 2007									
		32. Registrar's Signature Jean S. Apke									

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attend
within 24 hours after death

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

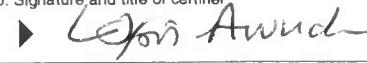
Reg. No. 2007 04141

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Mary Lou Kent</i>		2 11 07		3 pm M
4a. Facility Name (If not institution, give street and number) Manor Care Rossville		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
5. Social Security Number 216-30-1137		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) March 15, 1935
9. Birthplace (State or Foreign Country) Baltimore, MD		10. State MD		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10a. Street and Number 17B Mopec Circle		10b. County Baltimore		10c. City, Town or Location Nottingham
10e. Zip Code 21236		10f. Zip Code 21236		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: N/A		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White
14. Race - American Indian, Black, White, etc.		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker
16b. Kind of Business/Industry At Home		17. Father's Name (First, Middle, Last) George Wheatley		18. Mother's Name (First, Middle, Maiden Surname) Eunice Wheatley
19a. Informant's Name/Relationship (Type, Print) H. Fred Cimildora		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Edgemere Ave. Baltimore, MD 21219		19c. Date 2/15/2007
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Evans Funeral Chapel		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel		20c. Location - City or Town, State Forest Hill, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death LUNG CANCER.		
a. Due to (or as a consequence of):				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC EMPHYSEMA		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
29c. License number D0061789		29d. Date signed (Month, Day, Year) FEBRUARY, 12, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORRAINE OFOLI-AWUAH, 9106 PHILADELPHIA ROAD, STE 208, BALTIMORE MD 21237		31. Date filed (Month, Day, Year) FEB 13 2007		
32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend #17, per FD, g864, 2/13/07 TI
State Registrar

Certificate of Death

Reg. No.

2007 04142

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death	
	Darry R Kane							Month	Day	Year		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death				
	Genesis Evening Parkway				Baltimore			Baltimore City				
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)			
	219 77 8979		1 AM 2 F	77 Yrs.	Months	Days	Hours	Min.	08-02	1959	MARYLAND	
Usual Residence of Decedent												
10a. State	10b. County	10c. City, Town or Location								10d. Inside City Limits		
MD		BALTIMORE								1 Yes 2 No		
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?					
1809 North Broadway				21213			USA					
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
1 Never Married 2 Married 3 Widowed 4 Divorced		1 Yes 2 No If Yes, Give Year or Dates:			1 Yes 2 No Specify:			Specify: BLACK				
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry					
Elementary/Secondary (0-12)		College (1-4 or 5+)		NA								
17. Father's Name (First, Middle, Last)												
Joseph Joseph F. Kane, Jr.				FAIRE			ESTHER MAE CARVER					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
NADINE E		KANE			1809 N. BROADWAY BALTIMORE 21213							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State				
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		TRINITY CEM			2-12-2007			BALTIMORE MARYLAND				
21. Signature of Funeral Service Licensee				22. Name and Address of Facility								
Philip A. Weatherford				PHILIP A. WEATHERFORD FUNERAL SERVICE 21213								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death)												
a. HIV/AIDS Due to (or as a consequence of):												
b. Due to (or as a consequence of):												
c. Due to (or as a consequence of):												
d. Due to (or as a consequence of):												
Approximate Interval Between Onset and Death Years												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
IF FEMALE:		23c. If yes, outcome of pregnancy			23d. Date of delivery							
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
Liver failure > hepatitis C Failure to thrive												
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown												
24a. Was an autopsy performed? 1 Yes 2 No												
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No												
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one)										
		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work?		28d. Describe how injury occurred					
1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				M	1 Yes 2 No							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)		29b. Signature and title of certifier										
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number			29d. Date signed (Month, Day, Year)				
		Wendy Kloesz MD CPTI Nichols St Suite 4502 Towson MD 21204			D 31295			2/8/07				
31. Date filed (Month, Day, Year)		32. Registrar's Signature										
FEB 13 2007		James B. Lester										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, a Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

**Physician
/Medical
Examiner**

		1. Decedent's Name (First, Middle, Last) EDWIN LEE						2. Date of Death Month Day Year 02/11/2007	3. Time of Death 1:35 PM			
		4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death				
		5. Social Security Number 220-20-2280	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) NOV. 26, 1927	9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location Baltimore 10d. Inside City Limits 1 X Yes 2 □ No										
		10e. Street and Number 6010 Sefton Avenue			10f. Zip Code 21214			10g. Citizen of What Country? USA				
		11. Marital Status 1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? X Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: Packer			14. Race - American Indian, Black, White, etc. Specify: Asian			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Packer			16b. Kind of Business/Industry American Can Company				
		17. Father's Name (First, Middle, Last) Ling Lee				18. Mother's Name (First, Middle, Maiden Surname) Marie Chin						
		19a. Informant's Name/Relationship (Type, Print) Maureen Frances Lee-sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6010 Sefton Avenue-Baltimore, Maryland 21214							
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery			Date 2-15-07	20c. Location - City or Town, State Woodlawn, Maryland			
		21. Signature of Funeral Service Licensee Conrad L McFadden			22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATIONS SERVICES			8800 Harford Road Parkville, MD 21234				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracerebral Bleeding						Approximate Interval Between Onset and Death				
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Recurrent intracerebral Bleeding										
		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown			23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sick sinus Syndrome Hypertension Hyperthyroidism A-fib						23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown				
		25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)				24a. Was an autopsy performed? 1 □ Yes 2 X No			24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No	
		27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5601 LOCH RAVEN BLVD. BALTIMORE, M.D. 21239
		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Wai Cee			29c. License number RES-000	29d. Date signed (Month, Day, Year) 2/11/2007
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEI CEE, MD. 5601 LOCH RAVEN BLVD. BALTIMORE, M.D. 21239						31. Date filed (Month, Day, Year) FEB 13 2007			32. Registrar's Signature John B. Hall	

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

**Physician
/Medical
Examiner**

**Funeral
Director**

**State
Registrar**

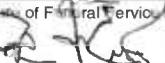
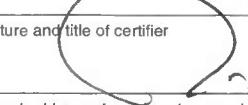
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04144

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Luce Marie Lauture							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 11:20 P M
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice			4b. City, Town, or Location of Death Timonium			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 579-62-2122	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) JULY 9, 1915			9. Birthplace (State or Foreign Country) Haiti	
To Be Completed by Funeral Director	10a. State MD 10b. County 10c. City, Town or Location Baltimore							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1708 Lakeside Ave.			10f. Zip Code 21218			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Haitian			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry At Home		
	17. Father's Name (First, Middle, Last) Rupert Nicolas				18. Mother's Name (First, Middle, Maiden Surname) Ines Bernier				
	19a. Informant's Name/Relationship (Type, Print) Karen M. Durham- Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6170 Radecke Ave. Baltimore, Maryland 21206					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens Of Faith Cemetery			Date 2/14/2007	20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death
	a.  Due to (or as a consequence of):								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSP. 2							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 	29c. License number D48725						29d. Date signed (Month, Day, Year) 2/12/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR TARIQ MAHMUD 2300 Dolaney Valley Rd. Timonium, MD 21093								
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007	32. Registrar's Signature 							

February 10, 2007 @ 11:20 p.m

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

LUCE LAUTURE
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 11 5

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

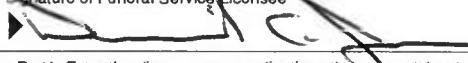
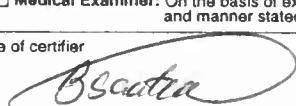
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and
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State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death				
Barry Lewis		02 08 2007				6:35 PM				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death				
Good Samaritan Hospital		Baltimore								
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 49	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 09/30/1957	9. Birthplace (State or Foreign Country) Maryland		
218-64-1094										
Usual Residence of Decedent								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State Maryland	10b. County	10c. City, Town or Location Baltimore								
10e. Street and Number 5212 Craig Avenue		10f. Zip Code 21212				10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction						
17. Father's Name (First, Middle, Last) Harry Lewis				18. Mother's Name (First, Middle, Maiden Surname) Lonnie Gray						
19a. Informant's Name/Relationship (Type, Print) John Tillman / Brother								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4006 West Franklin Street, Baltimore, Maryland 21229		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 02/13/2007		20c. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
<p>a. Advanced Liver disease Due to (or as a consequence of):</p> <p>b. End Stage renal disease Due to (or as a consequence of):</p> <p>c. Sepsis Due to (or as a consequence of):</p> <p>d.</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number REG 000				29d. Date signed (Month, Day, Year) February 8, 2007				
30. Name and address of person who completed use of death (Item 23a) (Type, Print) Barbara Saatian, Good Samaritan Hospital, Baltimore, MD										
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician
/Medical
Examiner

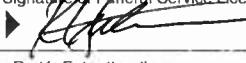
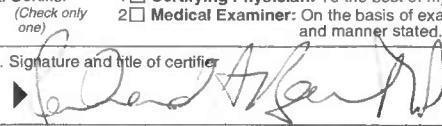
Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division or Vital Records, P.O. Box 68760,
Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death Hour Minute AM/PM	
Norma M. Lang		February 9, 2007				4:00P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
47 Maple Dale Avenue		Ferndale				Anne Arundel	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
213-28-6822			75 Yrs.		April 16, 1931	MD	
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
MD	Anne Arundel	Ferndale					
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?	
47 Maple Dale Avenue		21061				U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Social Security Administration		16b. Kind of Business/Industry Government			
17. Father's Name (First, Middle, Last) William Meinecke				18. Mother's Name (First, Middle, Maiden Surname) Frances Zacharda			
19a. Informant's Name/Relationship (Type, Print) Timothy Lang /Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Maple Dale Avenue Ferndale MD 21061			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Cremation		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date Feb 17, 2007	20c. Location - City or Town, State Stevensville, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of): <i>Hypertensive cardiovascular disease</i> b. Due to (or as a consequence of): <i>Hyperlipidemia</i> c. Due to (or as a consequence of):</p>							
Approximate Interval Between Onset and Death 10 yr 6 mos							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number N13526				29d. Date signed (Month, Day, Year) 2/2/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Baum M.D. 1600 Crian Hwy. South Suite 410 Glen Burnie MD 21061							
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Lomp				2. Date of Death Month February	3. Time of Death Year Day 10 2007
	4a. Facility Name (If not institution, give street and number) Morningside House of Friendship				4b. City, Town, or Location of Death Hanover	4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 216-03-2394	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) Nov. 24, 1910	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel				10c. City, Town or Location Hanover	
To Be Completed by Funeral Director	10e. Street and Number 7548 Old Telegraph Road			10f. Zip Code 21076	10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 8	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Duplicating Department	16b. Kind of Business/Industry McCormick Spice	
	17. Father's Name (First, Middle, Last) John Dreyer			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Anhalt		
	19a. Informant's Name/Relationship (Type, Print) Mr. Louis Lomp Jr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 M Nichols Street Bel Air Maryland 21014		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► RL			20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park	Date Feb. 15, 2007	20c. Location - City or Town, State Glen Burnie, MD
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Mo1411			22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death 5 yrs.		
Medical Certification: To Be Completed by Physician/Medical Examiner	a. CORONARY ARTERY DISEASE Due to (or as a consequence of):					
	b. _____ c. _____ d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier ► Donna M. Eversley MB		29c. License number D0054739			29d. Date signed (Month, Day, Year) FEBRUARY 12th 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DONNA EVERSLY 7845 OAKWOOD RD. STE 204 Glen Burnie, Md. 21061						
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007	32. Registrar's Signature Donna M. Eversley				

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 148

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death				
	JACK LISSY							Month Day Year		11:05 PM				
4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE							4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A					
Funeral Director	5. Social Security Number 217-09-6004		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 04/26/1918	9. Birthplace (State or Foreign Country) PA						
To Be Completed by Funeral Director	Usual Residence of Decedent													
	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 4007 LABYRINTH ROAD				10f. Zip Code 21215				10g. Citizen of What Country? U.S.A					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) ENGINEER			16b. Kind of Business/Industry BALTIMORE CITY PUBLIC SCHOOLS							
	17. Father's Name (First, Middle, Last) HERMAN LISSY				18. Mother's Name (First, Middle, Maiden Surname) LOUISE BRUNNER									
	19a. Informant's Name/Relationship (Type, Print) JOAN DAGRADY/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 EGRET STREET - NEW ORLEANS, LA. 70124									
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW YOUNG MEN			Data 02/11/2007		20c. Location - City or Town, State WOODLAWN, MD						
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Michael Kruger													
	22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS										Approximate Interval Between Onset and Death			
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown										IF FEMALE: 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AORTIC STENOSIS, CORONARY ARTERY DISEASE PACE MAKER PLACEMENT										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined										28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Nilesh J. Patel M.D.			
	29c. License number D 64957										29d. Date signed (Month, Day, Year) FEBRUARY 7, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NILESH J. PATEL, MD. 2401 WEST BELVEDERE AVE. BALTIMORE, MD 21215										31. Date filed (Month, Day, Year) FEB 13 2007			
	32. Registrar's Signature Nilesh J. Patel										33. Original			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
1- For Amend #1, per MD, g864, 2/13/07 II Certificate of Death
State Registrar Reg. No. 2007 04149

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Glen Sterling McCraw, Sr.								2. Date of Death Month 02 Day 06 Year 2007	3. Time of Death 4:35AM
	4a. Facility Name (If not institution, give street and number) Baltimore VA Medical Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-44-3208	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 11 17 47	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County NA 10c. City, Town or Location Baltimore								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2912 Winham Road				10f. Zip Code 21216			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1970			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) 11th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodial Worker			16b. Kind of Business/Industry Hospital		
	17. Father's Name (First, Middle, Last) Paul McCraw								18. Mother's Name (First, Middle, Maiden Surname) Mary C. McCraw	
	19a. Informant's Name/Relationship (Type, Print) Deborah McCraw-Wife								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 Winham Road, Baltimore, Md 21216	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metro Crematory Inc 2/9/07				20b. Place of Disposition (Name of cemetery, crematory or other place) 4300 Wabash Ave, Baltimore, Md 21215			Date		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee James A. Thompson Jr.								20c. Location - City or Town, State Baltimore, Md	
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke								Approximate Interval Between Onset and Death 3 days	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	5 Pending investigation 6 Could not be determined				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 101 Glebe Street Baltimore, MD 21201			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Melissa Pant, MD								29c. License number P20874	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melissa Pant, MD								29d. Date signed (Month, Day, Year) 2-6-07	
	31. Date filed (Month, Day, Year) FEB 13 2007				32. Registrar's Signature John S. Jones					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

hygiene
2007 04150
Reg. No.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Manuel Magram						2. Date of Death Month Day Year February 10 2007		3. Time of Death 12:10 A M			
Funeral Director		4a. Facility Name (If not institution, give street and number) Baltimore Rehabilitation Extended Care			4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A				
To Be Completed by Funeral Director		5. Social Security Number 213-12-4836		6. Sex X M 2 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 12, 1921	9. Birthplace (State or Foreign Country) Russia				
		Usual Residence of Decedent		10a. State MD		10b. County Baltimore		10c. City, Town or Location Pikesville			10d. Inside City Limits 1 Yes 2 No		
		10e. Street and Number 1500 Bedford Ave. Apt. #303					10f. Zip Code 21208		10g. Citizen of What Country? USA				
		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman			16b. Kind of Business/Industry G&E Contractors			16c. Date of Death Feb. 12, 07			
		17. Father's Name (First, Middle, Last) Yehuda Magram					18. Mother's Name (First, Middle, Maiden Surname) Eva Shay			19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 538 3rd Ave. Rio Bell, Ca 95562			
		19a. Informant's Name/Relationship (Type, Print) Joanne Magram - Daughter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory			20c. Location - City or Town, State Baltimore, MD			
		21. Signature of Funeral Service Licensee Kim MacLeod					22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228						
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death					
Medical Certification: To Be Completed by Physician/Medical Examiner		a. _____ Due to (or as a consequence of): Congestive Heart Failure											
		b. _____ Due to (or as a consequence of): Severe Mitral Regurgitation											
		c. _____ Due to (or as a consequence of): Renal Insufficiency											
		d. _____ Due to (or as a consequence of):											
		IF FEMALE:		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown						23d. Date of delivery Month Day Year			
		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown											
		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No									
		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier George E. Wicks III M.D.		29c. License number 041365		29d. Date signed (Month, Day, Year) February 10, 2007									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George E. Wicks III M.D. 3900 Loch Raven Boulevard, Baltimore, MD 21218													
31. Date filed (Month, Day, Year) FFB 13 2007		32. Registrar's Signature Anna B. Lester											
State Registrar													

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, **The Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

07-01090

Daniel W. Maenner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04151

1- For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death 0442 hrs	
Daniel W. Maenner Sr.				February 9, 2007					

**Funeral
Director**

4a. Facility Name (if not institution, give street and number) Sinai Hospital			4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
5. Social Security Number 218-36-8403	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) Oct. 28, 1939	9. Birthplace (State or Foreign Country) MD			

To Be Completed by Funeral Director

10a. State MD	10b. County Baltimore City	10c. City, Town or Location Baltimore					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2803 Cheswolde			10f. Zip Code 21209			10g. Citizen of What Country? USA		

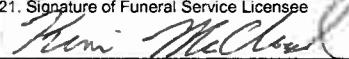
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: white	14. Race - American Indian, Black, White, etc. Specify: white
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Personnel	16b. Kind of Business/Industry UPS
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17. Father's Name (First, Middle, Last) Joseph Maenner	18. Mother's Name (First, Middle, Maiden Surname) Edith Craft
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19a. Informant's Name/Relationship (Type, Print) Daniel W. Maenner Jr. - Son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 764 A. Undercliff Ave. Edgewater, NJ 07020
---	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory	Date Feb. 12, 07	20c. Location - City or Town, State Baltimore, MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228
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2007

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 9, 2007
---	---------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
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31. Date filed (Month, Day, Year) FEB 13 2007	32. Registrar's Signature 
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

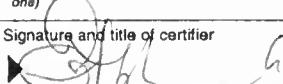
Reg. No. 2007 04 152

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last) John Samuel Madison						2. Date of Death Month FEB Day 08 Year 2007		3. Time of Death 2235 M		
		4a. Facility Name (If not institution, give street and number) ST AGNES HOSPITAL			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death				
		5. Social Security Number 226-24-3138		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 4-19-1926	9. Birthplace (State or Foreign Country) VA			
		Usual Residence of Decedent ND Baltimore						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
		10e. Street and Number 775 Linnard Street			10f. Zip Code 21229			10g. Citizen of What Country? USA				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
		15. Decedent's Education (Specify only highest grade completed) 9th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist			16b. Kind of Business/Industry Insulation Company				
		17. Father's Name (First, Middle, Last) Charlie Madison			18. Mother's Name (First, Middle, Maiden Surname) Mary Johnson							
		19a. Informant's Name/Relationship (Type, Print) Rovenia Madison (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 775 Linnard St., Baltimore, MD 21229							
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest			Date 2/15/2007	20c. Location - City or Town, State Owings Mills, MD			
		21. Signature of Funeral Service Licensee Augustine C. Greene			22. Name and Address of Facility Augustine C. Greene Funeral Services 5151 Baltw. Nati'l Pike, Baltimore, MD 21229							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer						Approximate Interval Between Onset and Death Unknown				
		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): 										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D0063025			29d. Date signed (Month, Day, Year) FEB 08 2007				
		29b. Signature and title of certifier 			29c. License number AAMIR CHEEMA M.D.			29d. Date signed (Month, Day, Year) M.D.				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5124 - STONE SHOP CIRCLE, OWINGS MILLS, MD 21117										
State Registrar		31. Date filed (Month, Day, Year) FEB 13 2007			32. Registrar's Signature 							

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Division of Vital Records, P.O. Box 68760,

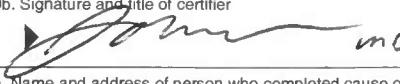
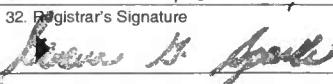
MADISON, JOHN SAMUEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01153

1- For State Registrar		1. Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of death			
		ROSE M. MORGANTE				Month Day Year			FEBRUARY 4, 2007 8:15 PM			
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number)				4b. City/Town, or Location of Death			4c. County of Death			
		The Johns Hopkins Hospital				Baltimore City						
Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
		012-14-8677		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	85 Yrs.	Months	Days	Hours	Min.	2-18-1921	Massachusetts	
To Be Completed by Funeral Director		Usual Residence of Decedent				10d. Inside City Limits						
		10a. State		10b. County		10c. City, Town or Location					10d. Inside City Limits	
		MD		Howard		Ellicott					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?		
		3020 North Ridge Road				21043				USA		
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White			
		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
		Elementary/Secondary (0-12)		College (1-4 or 5+)		Nurse				Medical		
		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
		William P. LaSpina				Rosalie Scaletta						
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
		William M. Morgante/Son		3542 Lower Mill Court, Ellicott City, MD 21043								
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		National Cemetery		2-9-2007		Bourne, MA				
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		Joseph Russo Funeral Home						
		Joanna E. Ellberry		814 American Legion Highway Roslindale, MA 82131								
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death		
		Immediate Cause (Final disease or condition resulting in death)								2 days		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
		<p>a. Myocardial Infarction Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>								20 years		
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify) _____		23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?		
										1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier  mo		29c. License number RES-1006				29d. Date signed (Month, Day, Year) FEBRUARY 5, 2007				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
		JOHN KOETTKE MD 600 WOLFE ST, BALTIMORE, MD 21287										
State Registrar		31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04154

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emma Lee Missel							2. Date of Death Month Day Year February 07 2007	3. Time of Death 12:30 PM
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center			4b. City, Town, or Location of Death Gaithersburg			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 126-12-5638	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) June 07 1911	9. Birthplace (State or Foreign Country) SC		
To Be Completed by Funeral Director	10a. State Maryland				10b. County Montgomery	10c. City, Town or Location Gaithersburg	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 333 Russell Avenue				10f. Zip Code 20877		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: College (1-4 or 5+) 4		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Household		
	17. Father's Name (First, Middle, Last) William Morgan				18. Mother's Name (First, Middle, Maiden Surname) Emma Lee Andrews				
	19a. Informant's Name/Relationship (Type, Print) George Missel (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 Russell Ave. Gaithersburg, MD 20877				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date Feb. 12 2007	20c. Location - City or Town, State Baltimore, Maryland	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stallings Funeral Home. P.A. 3111 Mountain Road, Pasadena, MD 21122				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death years				
	<p>a. multi-infarction dementia Due to (or as a consequence of):</p> <p>b. atrial fibrillation Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 				29c. License number D19284		29d. Date signed (Month, Day, Year) February 9, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John R. Melnick 311 Russell Ave Gaithersburg, Md. 20877								
	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene
1- For Amend #12 Per FH G864 2/13/07 JH Certificate of Death Reg. No. 2007 04155

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSE MILLER							2. Date of Death Month Day Year Feb 08 2007	3. Time of Death M
	4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A		
Funeral Director	5. Social Security Number 214-03-3269		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	B. Date of Birth (Month, Day, Year) 10/10/1912	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent		10a. State MD 10b. County N/A 10c. City, Town or Location BALTIMORE						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 1212 LINDEN GREEN			10f. Zip Code 21217			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 24		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) OWNER OPERATOR		16b. Kind of Business/Industry GROCERY STORE				
	17. Father's Name (First, Middle, Last) ISRAEL MILLER			18. Mother's Name (First, Middle, Maiden Surname) CECELIE ROSEN					
	19a. Informant's Name/Relationship (Type, Print) MARVIN MILLER / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 LINDEN GREEN - BALTIMORE, MD. 21217			Date 02/11/2007	20c. Location - City or Town, State BALTIMORE, MD		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Scott M. Cattell		20b. Place of Disposition (Name of cemetery, crematory or other place) ADATH YESHURUN						
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarct Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. hypertension Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <15 min
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dependent						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, MD			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier ► Dr. Eugene M. Miller MD		29c. License number D44817			29d. Date signed (Month, Day, Year) Feb 08 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Eugene M. Miller MD 2434 2 Belvedere Ave Baltimore								
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature ► [Signature]						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #5 Per EH G866 4/04/07 JH

Certificate of Death

2007 04 156

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine E. Neville				2. Date of Death Month Day Year February 10, 2007	3. Time of Death P M 6:15		
	4a. Facility Name (If not institution, give street and number) 7424 Poplar Avenue		4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 218-26-6338	6. Sex 1 □ M 2 X F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) February 23, 1932	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Dundalk						10d. Inside City Limits 1 □ Yes 2 X No	
	10e. Street and Number 7424 Poplar Avenue			10f. Zip Code 21224		10g. Citizen of What Country? USA		
Physician /Medical Examiner	11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 years	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Housewife	16b. Kind of Business/Industry Own Home					
Medical Certification: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frederick L. Hammerbacker			18. Mother's Name (First, Middle, Maiden Surname) Charlotte Haslup				
	19a. Informant's Name/Relationship (Type, Print) Catherine Weber Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8611 Esquire Road, Sparrows Point, Maryland 21219					
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date February 14, 2007	20c. Location - City or Town, State Baltimore City, MD.				
21. Signature of Funeral Service Licensee Anthony Connelly		22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Ovarian Cancer						Approximate Interval Between Onset and Death 28 Months		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {								
a. Due to (or as a consequence of): 		b. Due to (or as a consequence of): 		c. Due to (or as a consequence of): 		d. 		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown	
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)					24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No
27. Manner of death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) 		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred 		
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 					28f. Location (Street and Number or Rural Route Number, City or Town, State) 	
29b. Signature and title of certifier Janet Cooper MD		29c. License number D46118			29d. Date signed (Month, Day, Year) Feb 12th, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANET COOPER MD 1447 York Rd Lutherville MD 21093		31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Janet Cooper				

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

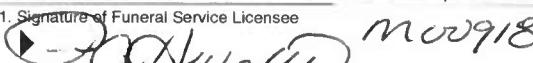
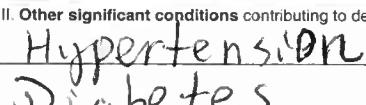
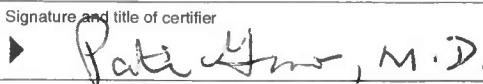
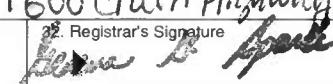
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04157

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Charles Niedergesahs						2. Date of Death Month Day Year February 9, 2007	3. Time of Death 5:30 A M		
	4a. Facility Name (If not institution, give street and number) 1381 Odenton Road			4b. City, Town, or Location of Death Odenton			4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 217-40-5857	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) Feb. 7, 1943	9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel			10c. City, Town or Location Odenton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 1381 Odenton Road				10f. Zip Code 21113			10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Truck Driver		16b. Kind of Business/Industry Pro Hauling Towing						
17. Father's Name (First, Middle, Last) Carl Niedergesahs				18. Mother's Name (First, Middle, Maiden Surname) Helen M. Lowman						
19a. Informant's Name/Relationship (Type, Print) Mrs. Helen M. Benson/ Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Lane Catonsville, MD 21228						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cem.		Date Feb. 12, 2007	20c. Location - City or Town, State Baltimore MD					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.  Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 10 years		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29b. Signature and title of certifier 		29c. License number D0056046		29d. Date signed (Month, Day, Year) 2/9/2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Gao, 1600 Crain Highway South, Suite 406, Glen Burnie MD 21061										
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 18 per fh g864 2-13-07 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04158
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERALDINE J. NUTTRELL							2. Date of Death Month Day Year FEBRUARY 11, 2007	3. Time of Death 7:12 AM
	4a. Facility Name (If not institution, give street and number) MERCY MEDICAL CENTER			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-12-0317	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) July 30, 1920	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent									
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1101 N. Calvert Street Apt. 403				10f. Zip Code 21202				10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Branch Manager				16b. Kind of Business/Industry Banking	
17. Father's Name (First, Middle, Last) Walter Johnson					18. Mother's Name (First, Middle, Maiden Surname) Helen Fitzgerald (link)				
19a. Informant's Name/Relationship (Type, Print) Donald L. Allewalt (Per. Rep.)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 W. Pennsylvania Ave. Towson, Maryland 21204				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Druid Ridge Cemetery					20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 2-17-07	20c. Location - City or Town, State Pikesville, Maryland	
21. Signature of Funeral Service Licensee George J. Ferrante					22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon cancer Approximate Interval Between Onset and Death									
<p>a. Due to (or as a consequence of): Colon cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29b. Signature and title of certifier Mark F. Brazie, MD		29c. License number P18591							
		29d. Date signed (Month, Day, Year) FEBRUARY 11, 2007							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK F. BRAZIE 301 SAINT PAUL PLACE, BALTIMORE MARYLAND 21202									
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Mark F. Brazie							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 159

3. Time of Death

2. Date of Death
Month Day Year
February 11, 2007

8:10 P M

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) MARIE C. PHELAN				2. Date of Death Month Day Year February 11, 2007				3. Time of Death 8:10 P M		
4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium				4c. County of Death Baltimore		
5. Social Security Number 213-03-9436		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Sept. 30, 1919		9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent 10a. State MD 10b. County Baltimore				10c. City, Town or Location Timonium				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 2300 Dulaney Valley Road				10f. Zip Code 21093				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Secretary				16b. Kind of Business/Industry Hospital		
17. Father's Name (First, Middle, Last) Harry Burlage				18. Mother's Name (First, Middle, Maiden Surname) Barbara Schoepplein						
19a. Informant's Name/Relationship (Type, Print) Francis X. Phelan, Jr-son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 Windwood Road-Baltimore, Maryland 21212						

20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Parkwood Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery	Date 2-15-07	20c. Location - City or Town, State Parkville, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES	8800 Harford Road Parkville, MD 21234					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death		
<p>a. END STAGE DEMENTIA Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D43721				29d. Date signed (Month, Day, Year) Feb. 12, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 Dulaney Valley Rd Timonium, MD 21093								
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 						

8:10 P.M.
Baltimore, Maryland 21215-0036

FEBRUARY 11, 2007
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04160
Reg. No.

1-
For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

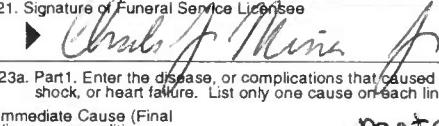
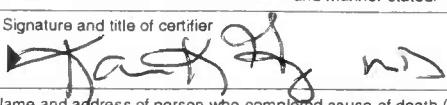
Division of Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
<i>Thelma R. PEARL</i>		Feb. 9 2007				3:35 AM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
<i>OAK CREST</i>		<i>BALTIMORE</i>				<i>Baltimore</i>	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month Day Year	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
213-03-6744		91 Yrs.			09-30-1915		
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>3536 Woodring Avenue</i>			10f. Zip Code <i>21234</i>			10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>2</i>		16b. Kind of Business/Industry <i>Secretary Legal</i>			
17. Father's Name (First, Middle, Last) <i>Frederick C. Gunther</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Effie A. Wells</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Thomas Pearl - Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3217 Evergreen Avenue Baltimore, MD 21214</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gardens of Faith Cem.</i>		Date <i>02/12/2007</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <i>Leonard J. Ruck, Inc. 5305 HarfordRoad Baltimore, MD 21214</i>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>metastatic lung cancer</i>							
Approximate Interval Between Onset and Death <i>1 year</i>							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive heart failure, Atrial fibrillation</i> <i>coronary artery disease</i>				23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred			
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Karen K. Ging MD</i>		31. Date filed (Month, Day, Year) <i>FEB 13 2007</i>			32. Registrar's Signature 		
33. Date signed (Month, Day, Year) <i>FEB 9, 2007</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 161

3-Time of Death

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) Beverly Mae Pitt				2. Date of Death Month Day Year February 9, 2007		3-Time of Death 9:45A M	
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) 1103 Leonard Drive				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 219-30-4319	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months 72	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) July 23, 1934	9. Birthplace (State or Foreign Country) MD	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD				10b. County Anne Arundel			10c. City, Town or Location Glen Burnie
									10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 1103 Leonard Drive		10f. Zip Code 21060				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Clerical Work		16b. Kind of Business/Industry N.A.S.A.					
17. Father's Name (First, Middle, Last) Elsworth Arnold				18. Mother's Name (First, Middle, Maiden Surname) Doris Schubert					
19a. Informant's Name/Relationship (Type, Print) Mrs. Cynthia Fowler /Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 786 Powhatan Beach Road Pasadena MD 21122					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery			Date Feb. 12, 2007	20c. Location - City or Town, State Brooklyn Park			
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Singleton Funeral Home, P.A.			1 Second Avenue SW Glen Burnie, MD 21061				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Metastatic lung cancer</i>							
		a. Due to (or as a consequence of):							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
Approximate Interval Between Onset and Death 5 years.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year				
					Date	Month	Day	Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]							
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alon N. Dennis		29c. License number 370555				29d. Date signed (Month, Day, Year) February 10, 2007			
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

07-01121

Dorothy Marie Parrish

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04162

1- For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0836 hrs
Dorothy Marie Parrish	February 10, 2007	

**Funeral
Director**

4a. Facility Name (if not institution, give street and number) 71 S. Paula Street	4b. City, Town, or Location of Death Laurel	4c. County of Death Anne Arundel			
5. Social Security Number 214-88-1834	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 33 Yrs.	If Under 1 Year Months Days Hours Min		
				8. Date of Birth (MM/DD/YYYY) 01/04/1974	9. Birthplace (State or Foreign Country) MD

Baltimore, MD 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23 or 26 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Pasadena	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 1216 Hillside Road		10f. Zip Code 21122	10g. Citizen of What Country? USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:		

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Homemaker

17. Father's Name (First, Middle, Last) Ralph R. Moorhead	18. Mother's Name (First, Middle, Maiden Surname) Carla Page
19a. Informant's Name/Relationship (Type, Print) Ralph R. Moorhead (father)	

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 Hillside Road, Pasadena, MD 21122	Date Feb. 15	20c. Location - City or Town, State Baltimore, Maryland
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.	
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20c. Location - City or Town, State Baltimore, Maryland	

21. Signature of Funeral Service Licensee	22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <u>Methadone intoxication</u> Due to (or as a consequence of):	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ c. _____ d. _____	
--	--

<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #204,27,28a-f, per ME, g865, 3/14/07 TT	
---	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	---

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) 2/10/2007	28b. Time of Injury Fnd 8:30 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unk
--	---	------------------------------------	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) mobile home	28f. Location (Street and Number or Rural Route Number, City or Town, State) Laurel, MD 71 S. Paula St.
---	--

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Tasha Greenberg MD</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 11, 2007
--	--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
--

31. Date filed (Month, Day, Year) FEB 13 2007	32. Registrar's Signature <i>Leanne B. Jacobs</i>
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ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 163

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death	
	Amy				Month	Day	Year	8:38 P M
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death		4c. County of Death	
	The Johns Hopkins Hospital				Baltimore City		N/A	
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	219 16 0060		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F X	86 Yrs.	Months	Days	Hours	Min.
Usual Residence of Decedent								
10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits
MD.		N/A		BALTIMORE				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No X
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?	
1401 N. LAKWOOD AVE APT. 330				21213			USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced X		1 <input type="checkbox"/> Yes X <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> X Specify:			Specify: BLACK
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry
Elementary/Secondary (0-12) 11TH		College (1-4 or 5+)		ADMINISTRATION				HOSPITAL
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)			
WILLIAM WINDER					CELESTE THOMAS			
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
JOHN JONES / NEPHEW				1401 N. LAKWOOD AVE. APT. 330 Balto, Md. 21213				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State	
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		MT. ZION CEMETERY			FEB. 15, 2007		BALTIMORE, MD.	
21. Signature of Funeral Service Licensee								
Bernadine J. Scruggs								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
23b. Was decedent pregnant in the past 12 months?								
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown								
23c. If yes, outcome of pregnancy								
1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown								
23d. Date of delivery								
Month Day Year								
23e. Did tobacco use contribute to the cause of death?								
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed?								
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death?								
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner?								
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one)								
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death								
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury M								
28c. Injury at Work?								
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one)								
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier								
Matthew Koenig MD								
29c. License number								
D 0063682								
29d. Date signed (Month, Day, Year)								
February 10, 2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
Matthew Koenig 600 N. Wolfe Street Baltimore, MD 21287								
31. Date filed (Month, Day, Year)								
FEB 13 2007								
32. Registrar's Signature								
Elmer B. Apelt								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007-04164

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Teresa Rainey</i>		<i>February 22 2007</i>		<i>2:00 AM</i>
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>The Johns Hopkins Hospital</i>		<i>Baltimore</i>		<i>N/A</i>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>40 Yrs.</i>	If Under 1 Year Months Days Hours Min. <i>Dec 26, 1966</i>
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>
10e. Street and Number <i>314 South Spring Court</i>		10f. Zip Code <i>21231</i>		10g. Citizen of What Country? <i>United States</i>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1970</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Home</i>
17. Father's Name (First, Middle, Last) <i>Jerry Spell</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Sarah Rainey</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Mary Crutchfield - Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1218 North Spring Ct. Baltimore MD 21213</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Metro Crematory</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		Date <i>Feb. 12, 2007</i> 20c. Location - City or Town, State <i>Baltimore MD</i>
21. Signature of Funeral Service Licensee <i>Calvin L. Williams Jr., P.A.</i>		22. Name and Address of Facility <i>P.O. Box 11651 Baltimore MD 21229</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): <i>Atherosclerotic heart disease</i>				
b. Due to (or as a consequence of): <i>Diabetes</i>				
c. Due to (or as a consequence of): <i>Obesity</i>				
d. Due to (or as a consequence of): <i>Hypertension</i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of Certifier <i>Calvin L. Williams Jr., P.A.</i>		29c. License number <i>D0057145</i>		29d. Date signed (Month, Day, Year) <i>2/8/07</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Hand 315 N. Calvert 4th Floor, Baltimore, MD 21202</i>		32. Registrar's Signature <i>John A. Jones</i>		
31. Date filed (Month, Day, Year) <i>FEB 13 2007</i>				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04165

1- For
State
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death				3. Time of Death												
	Miriam Elizabeth Ritz							Month	Day	Year														
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death															
	Johns Hopkins Bayview Medical Ctr.				Baltimore City				N/A															
Usual Residence of Decedent																								
10a. State		10b. County		10c. City, Town or Location									10d. Inside City Limits											
Maryland		Baltimore		Dundalk									<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?				United States												
7607 Maple Road				21222																				
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.															
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: White															
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry															
Elementary/Secondary (0-12)		College (1-4 or 5+)		Bindery Worker					Books Binding															
17. Father's Name (First, Middle, Last)							18. Mother's Name (First, Middle, Maiden Surname)																	
Edward J. Stockum							Minnie Cassett																	
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)																				
Mr. Joseph C. Ritz (Husband)				7607 Maple Road Dundalk, Maryland 21222																				
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State														
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				Hilltop Service Corp.				2/12/2007		Towson, Maryland														
21. Signature of Funeral Service Licensee																								
► <i>Hassan Cass</i>																								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death																								
a. <i>ventricular fibrillation</i> minute																								
Due to (or as a consequence of):																								
b. <i>ischemic cardiomyopathy</i> years																								
Due to (or as a consequence of):																								
c. <i>coronary heart disease</i> years																								
Due to (or as a consequence of):																								
d. <i>Diabetes mellitus</i> years																								
IF FEMALE:				23c. If yes, outcome of pregnancy									23d. Date of delivery											
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown									Month Day Year											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													23e. Did tobacco use contribute to the cause of death?											
													<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown											
													24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner?													26. Place of Death (Check only one)											
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													<input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Pending investigation											
27. Manner of Death													28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred					
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide													M		<input type="checkbox"/> Yes <input type="checkbox"/> No									
													28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one)													29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)			
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													► Sheldon H. Gottheil, M.D., Cardiologist				D-16362				02/08/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)																								
Sheldon H. Gottheil, M.D. 4940 Eastern Ave, Baltimore, MD 21224																								
31. Date filed (Month, Day, Year)				32. Registrar's Signature																				
FEB 13 2007				<i>Sheldon H. Gottheil</i>																				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

04166

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lourena Yvonne Richardson					2. Date of Death Month Day Year February 9, 2007	3. Time of Death 14:51 M
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 080-30-2060	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 23, 1939	9. Birthplace (State or Foreign Country) NC	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD Anne Arundel 10b. County 10c. City, Town or Location Arnold					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1349 Jones Station Road			10f. Zip Code 21012	10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown		
	19a. Informant's Name/Relationship (Type, Print) Mr. Tremayne Richardson/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8267 Kramer Court Glen Burnie, MD 21061				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Vets Cem.	Date Feb. 16, 2007	20c. Location - City or Town, State Crownsville, MD		
	21. Signature of Funeral Service Licensee ► <i>R. J. Richardson</i>		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061				
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>{</p> <p>a. Due to (or as a consequence of): <i>Acute myocardial infarction</i></p> <p>b. Due to (or as a consequence of): <i>Stroke</i></p> <p>c. Due to (or as a consequence of): <i>Diabetes mellitus</i></p> <p>d.</p>					Approximate Interval Between Onset and Death <i>hour</i>	
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier ► <i>Elliott R. J. Richardson</i>		29c. License number 020094			29d. Date signed (Month, Day, Year) 2/12/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliott R. J. Richardson, M.D., 1911 Madison Park Drive, Glen Burnie, MD 21061						
	31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature <i>Patricia A. Gaskins</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 04167

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
		Dorothy M. Solomon		February 7 2007				22:37 M		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death				
Johns Hopkins Bayview		Baltimore				N/A				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
213-64-7382		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	52 Yrs.	Months	Days	10/07/1951	USA			
Usual Residence of Decedent										
10a. State	10b. County	10c. City, Town or Location					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
MD	N/A	Baltimore								
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?				
511 N. Ellwood Avenue			21224			USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, specify Cuban, Mexican, Puerto Rican, etc.			14. Race - American Indian, Black, White, etc. Specify: African American			
Elementary/Secondary (0-12)		College (1-4 or 5+)		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
12							Clerk		Goodwill	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
Eddie A. Bailey				Annie Belle Brown						
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Linda Harris / Sister		314 N. Ellwood Ave., Balt., MD 21224								
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date			20c. Location - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Maryland Natural Death		2/17/07			Laurel, MD			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility								
► J. T. Hussey		Hari P. Close Funeral Service, P.A. 5126 Belair Rd, Baltimore, MD 21206								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death								
Immediate Cause (Final disease or condition resulting in death)										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. Mitral valve dehiscence / 3rd degree heart block Due to (or as a consequence of):</p> <p>b. Gram negative rod bacteremia Due to (or as a consequence of):</p> <p>c. Respiratory arrest Due to (or as a consequence of):</p> <p>d.</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one)		29b. Signature and title of certifier ► Anne Hussey								
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES - 000								
29d. Date signed (Month, Day, Year) February, 07, 2007										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
Dr. Anne Hussey 9940 Eastern Avenue Baltimore, MD 21224										
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature Anne Hussey								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04168

For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

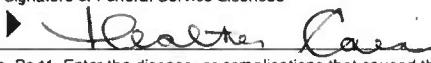
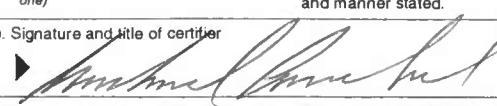
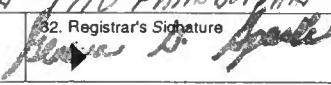
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at:

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Janet L. Sullivan		February 8, 2007				11:39 AM	
4a. Facility Name (If not institution, give street and number) 3496 Loganview Drive		4b. City, Town, or Location of Death Dundalk				4c. County of Death Baltimore Co.	
5. Social Security Number 218-28-4456		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 7, 1931	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Dundalk					
10e. Street and Number 3496 Loganview Drive		10f. Zip Code 21222				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Years		16b. Kind of Business/Industry Transportation Analyst			
17. Father's Name (First, Middle, Last) Daniel Stallings		18. Mother's Name (First, Middle, Maiden Surname) Elsie Appleby					
19a. Informant's Name/Relationship (Type, Print) Mr. Daniel L. Sullivan (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3496 Loganview Drive Dundalk, Maryland 21222					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombmt.		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gdns. 2/10/2007		Date		20c. Location - City or Town, State Middle River, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				Approximate Interval Between Onset and Death 15 years	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D33551				29d. Date signed (Month, Day, Year) FEBRUARY 9, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL AUBERBACH 9110 Philadelphia Rd H314, Baltimore, 21237							
31. Date filed (Month, Day, Year) FEB 13 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUISE VIRGINIA SMITH							2. Date of Death Month JANUARY	Day 30, 2007	Year 2007	3. Time of Death 3:30 A M
	4a. Facility Name (If not institution, give street and number) FOREST HAVEN NURSING HOME							4b. City, Town, or Location of Death CATONSVILLE	4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-28-8856	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) MARCH 19, 1929	9. Birthplace (State or Foreign Country) VIRGINIA				
To Be Completed by Funeral Director	10a. State MARYLAND							10b. County BALTIMORE	10c. City, Town or Location CATONSVILLE	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 701 EDMONDSON AVE.							10f. Zip Code 21228	10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME				
	17. Father's Name (First, Middle, Last) WILLIAM ARRINGTON							18. Mother's Name (First, Middle, Maiden Surname) LONIE L. FREEMAN			
	19a. Informant's Name/Relationship (Type, Print) WEBSTER ALEXANDER, III (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 TYSON DR. APT. 303 STAFFORD, VA 22554						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY				Date 2/1/2007	20c. Location - City or Town, State ALEXANDRIA, VA	
	21. Signature of Funeral Service Licensee 							22. Name and Address of Facility JENNINGS-MCMILLIAN FUNERAL HOME 200 WEST CAROLINA AVE., CREWE, VA 23930			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, starting with the final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
	a. <i>pneumonia</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death 2 wks									
	b. <i>Chronic obstructive pulmonary disease</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death 2 wks									
	c. <i></i> Due to (or as a consequence of):										
	d. <i></i> Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day			Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred						
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)										
	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 	29c. License number D31885				29d. Date signed (Month, Day, Year) 2/1/07					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael D. Karp, MD										
State Registrar	31. Date filed (Month, Day, Year) FEB 13 2007	32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007

01 170

3. Time of Death

2. Date of Death

Month

Day

Year

February 9, 2007

7:45 A M

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death				3. Time of Death
DONALD COLSON STATES					Month Day Year

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death
3939 Roland Avenue, Apt 314 Baltimore City					N/A

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
149-05-4397	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	91 Yrs.	Months	Days	Hours	Min.	Jan 26, 1916 Pennsylvania

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore City	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3939 Roland Avenue, Apt 314	21211	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12) 12	College (1-4 or 5+) Merchant Marine	Sea Commerce

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Thomas States	Esther Louise Seibert

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James J. Nolan, Jr. (Pers. Rep.)	1610 Landon Road, Towson, Maryland 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	Dulaney Valley Mem Grdns	2/14/2007	Timonium, Maryland

21. Signature of Funeral Service Licensee ► Martin D. Lawson	22. Name and Address of Facility
	MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	years
a. Due to (or as a consequence of): End stage renal disease	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
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25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____	26. Place of Death Check only one
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D25205	29d. Date signed (Month, Day, Year) February 9, 2007
--	-------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.Riley G.Smc 6701 N.Charles St. Balt. Md 21204	31. Date filed (Month, Day, Year) FEB 13 2007	32. Registrar's Signature Peter B. Aponte
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Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

125
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Minerva Mae Sick						2. Date of Death Month Day Year February 8, 2007	3. Time of Death 9:16A M
Funeral Director		4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice Care			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore	
To Be Completed by Funeral Director		5. Social Security Number 210-14-5393	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 7, 1926	9. Birthplace (State or Foreign Country) PA	
		Usual Residence of Decedent MD Baltimore			10c. City, Town or Location Owings Mills			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 83 N. Ritters Lane			10f. Zip Code 21117			10g. Citizen of What Country? USA	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker	16b. Kind of Business/Industry Own Home				
		17. Father's Name (First, Middle, Last) Palmer Allen			18. Mother's Name (First, Middle, Maiden Surname) Irene Traylor				
		19a. Informant's Name/Relationship (Type. Print) Walter G. Sick, Sr. Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 83 N. Ritters Lane, Owings Mills, MD 21117				
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Carroll Cremation		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation	Date 2/9/07	20c. Location - City or Town, State Hampstead, MD			
		21. Signature of Funeral Service Licensee ► E. Williams			22. Name and Address of Facility Eline Funeral Home	11824 Reisterstown Road Reisterstown, MD 21136			
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer of Liver						Approximate Interval Between Onset and Death months	
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	
		23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) hospice	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier ► Sharpen	
		29c. License number D 58303						29d. Date signed (Month, Day, Year) February 8 2007	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amelia L. Curran, ms 6701 N. Charles St Baltimore MD 21208							
State Registrar		31. Date filed (Month Day Year) FEB 13 2007			32. Registrar's Signature Shane B. Apel				

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

**1 - For
State
Registrar**

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 172

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

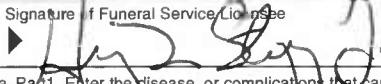
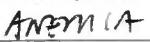
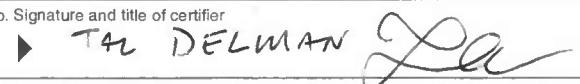
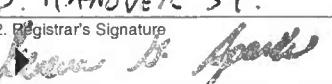
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
RAYMOND SWIGERT		FEBRUARY 7 2007		9:00 AM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
HARBOR HOSPITAL		BALTIMORE		N/A
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 10 1931
296-24-7047				9. Birthplace (State or Foreign Country) OH
Usual Residence of Decedent				
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie		
10e. Street and Number 118 Mountain Road Apt. 3A		10f. Zip Code 21060		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Heavy Equipment	16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) Ernest Swigert	18. Mother's Name (First, Middle, Maiden Surname) Helen Moore			
19a. Informant's Name/Relationship (Type. Print) William Swigert (brother)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Mountain RD. Apt. 3A 21060			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Maryland Veterans Cem	20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem	Date Feb. 12 2007	20c. Location - City or Town, State Crownsville, Maryland	
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to final death cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 YEAR 10 YEARS 1 DAY
a.  Due to (or as a consequence of):				
b.  Due to (or as a consequence of):				
c.  Due to (or as a consequence of):				
d.  Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		
28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 	29c. License number RS 000	29d. Date signed (Month, Day, Year) FEBRUARY 7, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAL DELMAN 3001 S. HANOVER ST.	BALTIMORE, MD 21225			
31. Date filed (Month, Day, Year) FEB 13 2007	32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04173

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SELMA SLOAN							2. Date of Death Month February Day 8 Year 2007	3. Time of Death 20:58 p. m.
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER							4b. City, Town, or Location of Death RANDALLSTOWN	4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 216-01-2693	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 10/05/1920	9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	10a. State MD 10b. County N/A 10c. City, Town or Location BALTIMORE							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 6316 GREENSPRING AVENUE #301				10f. Zip Code 21209		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER			16b. Kind of Business/Industry ACCOUNTING		
	17. Father's Name (First, Middle, Last) ISAAC TRUSS				18. Mother's Name (First, Middle, Maiden Surname) LENA FREEDMAN				
	19a. Informant's Name/Relationship (Type, Print) SUSAN CLOSIC / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 HAL COURT - BALTIMORE, MD 21209				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BETH JACOB ANSHE VESHEAR				20b. Place of Disposition (Name of cemetery, crematory or other place) 2/11/07		Date 2/11/07	20c. Location - City or Town, State ROSEDALE, MD	
	21. Signature of Funeral Service Licensee Jay May Jr.				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTROINTESTINAL BLEEDING . Approximate Interval Between Onset and Death								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER'S DEMENTIA, CANCER BREAST, ESSENTIAL HYPERTENSION								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29b. Signature and title of certifier Romanawany Rangewany MD		29c. License number DS4288		29d. Date signed (Month, Day, Year) February 8th 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Romanawany & Rangewany		31. Date filed (Month, Day, Year) FEB 13 2007						
	32. Registrar's Signature James B. Jones								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

39

39

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04174

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theresa Mary Weldon	2. Date of Death Month Day Year February 9, 2007	3. Time of Death 10:05AM
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Funeral Director	4a. Facility Name (If not institution, give street and number) Mariner Health of Glen Burnie	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Arundel
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Physician /Medical Examiner	5. Social Security Number 220-24-6718	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 12, 1913	9. Birthplace (State or Foreign Country) MD
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Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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Physician /Medical Examiner	10e. Street and Number 1136 Armistead Street	10f. Zip Code 21061	10g. Citizen of What Country? U.S.A.
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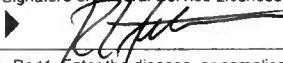
Physician /Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (11-40 or 5+) Homemaker	16b. Kind of Business/Industry Own Home
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Physician /Medical Examiner	17. Father's Name (First, Middle, Last) William Kram	18. Mother's Name (First, Middle, Maiden Surname) Theresa Paetow
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Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Louis E. Weldon/ Son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1136 Armistead Street Glen Burnie Maryland 21061
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Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park	Date Feb. 16, 2007	20c. Location - City or Town, State Glen Burnie, MD
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Physician /Medical Examiner	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061
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Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Approximate Interval Between Onset and Death
	a. <i>Coronary artery disease</i> Due to (or as a consequence of):	
	b. _____ Due to (or as a consequence of):	
	c. _____ Due to (or as a consequence of):	
	d. _____	

Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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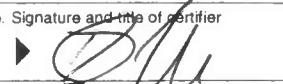
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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Physician /Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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Physician /Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
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Physician /Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
-----------------------------	--

Physician /Medical Examiner	29b. Signature and title of certifier 	29c. License number D 38958	29d. Date signed (Month, Day, Year) 2/9/07
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Physician /Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daljeet Singh Sidhu 208 Crom Highway SW Glen Burnie MD 21061
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Physician /Medical Examiner	31. Date filled (Month, Day, Year) FEB 13 2007	32. Registrar's Signature 
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 175
Reg. No.

1-
For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ETHEL W WATCHORN							2. Date of Death Month Day Year February 7, 2007	3. Time of Death 10:45P M
	4a. Facility Name (If not institution, give street and number) Fairhaven			4b. City, Town, or Location of Death Sykesville			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 215-24-0419	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 4, 1909	9. Birthplace (State or Foreign Country) , Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Carroll 10c. City, Town or Location Sykesville							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7200 Third Avenue			10f. Zip Code 21784			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: XX			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) William Winterson					18. Mother's Name (First, Middle, Maiden Surname) Edna Hyde			
	19a. Informant's Name/Relationship (Type, Print) Ann T Gundry					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POA 90 Smoketown Road Mertytown, Pennsylvania 19539			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) XX			20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory			Date 2/9/07	20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensed Dennis J. Green Knaps					22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Anorexia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Dysphagia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death Months
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colitis								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D34849			29d. Date signed (Month, Day, Year) February 8, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1645 Liberty Road Eldersburg Md 21784								
	31. Date filed (Month, Day, Year) FEB 13 2007			32. Registrar's Signature Leanne B. Speller					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 176

3. Time of Death

2. Date of Death

Month

Day

Year

February 12, 2007

10:45 AM

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)

Tyrone Williams

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

2. Date of Death

Month

Day

Year

February 12, 2007

10:45 AM

5. Social Security Number

212-76-5485

6. Sex

 M F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 24, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

 Yes No

10e. Street and Number

32 Deep Spring Ct.

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

 Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

 Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

P. Kindergarten N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Vending machine tech. Atkase Co.

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Robert Miller Williams

18. Mother's Name (First, Middle, Maiden Surname)

Viona Mae Nicholson

19a. Informant's Name/Relationship (Type, Print)

Viona Mae Williams - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1500 Bedford Pl. Apt 308 Pikesville, MD 21208

20a. Method of Disposition

 Burial Cremation Removal from State Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kingman PK.

Date

21. Signature of Funeral Service Licensee

Kensington, MD

22. Name and Address of Facility

3405 W. Franklin St.
Nancy M. Wallace Funeral Serv. Balt., MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

year

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy

 Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Unknown Other (Specify) _____

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

 Yes No Probably Unknown

25. Was case referred to medical examiner?

 Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DOA

Other:

 Nursing Home Residence Other (Specify) Hospice

27. Manner of Death

 Natural
 Accident
 Suicide
 Homicide5 Pending investigation
6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

 Yes No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► M. Anthony Riley, M.D.

29c. License number

D25205

29d. Date signed (Month, Day, Year)

February 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G.P.M.C. 6701 N. Charles St. Baltimore, MD 21208

31. Date filed (Month, Day, Year)

FEB 13 2007

32. Registrar's Signature

► M. Anthony Riley

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

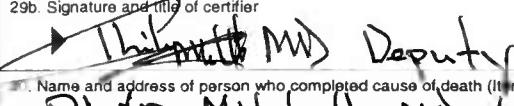
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 17

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hyun Soon Yi						2. Date of Death Month Feb. Day 09, Year 2007	3. Time of Death 7:20 P.M
	4a. Facility Name (If not institution, give street and number) 1 High Pine Court			4b. City, Town, or Location of Death Cockeysville			4c. County of Death Baltimore County	
Funeral Director	5. Social Security Number 216-06-5359	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 04, 1917	9. Birthplace (State or Foreign Country) Seoul, Korea	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore County 10c. City, Town or Location Cockeysville 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 1 High Pine Court			10f. Zip Code 21030			10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Korean		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 06		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Shin Tae Suk				18. Mother's Name (First, Middle, Maiden Surname) Kim Dann In			
	19a. Informant's Name/Relationship (Type, Print) Mr. Jun Bae Yi (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 High Pine Court Cockeysville, Maryland 21030			
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gar.			Date Feb. 12, 2007	20c. Location - City or Town, State Timonium, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 							
	22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease							
	Approximate Interval Between Onset and Death							
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 							
	29c. License number D18667							
	29d. Date signed (Month, Day, Year) February 10, 2007							
	31. Date filed (Month, Day, Year) FEB 13 2007							
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 178

1- For State Registrar		1. Decedent's Name (First, Middle, Last) Norman Francis Allard						2. Date of Death Month Day Year January 29, 2007		3. Time of Death 5:55AM		
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) N M S Health Care						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director		5. Social Security Number 258-34-6430	6. Sex M	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) June 8 1930	9. Birthplace (State or Foreign Country) Massachusetts		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland						10b. County Washington			10c. City, Town or Location Hagerstown	10d. Inside City Limits 1 Yes 2 No
		10e. Street and Number 14014 Marsh Pike						10f. Zip Code 21742			10g. Citizen of What Country? U.S.A.	
Physician /Medical Examiner		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1950		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White			
Medical Certification: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Nuclear Technician		16b. Kind of Business/Industry Power Plant					
		17. Father's Name (First, Middle, Last) Arthur Joseph Allard			18. Mother's Name (First, Middle, Maiden Surname) Yvonne Laura Savageau							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.		19a. Informant's Name/Relationship (Type, Print) Yvonne Barnaby / Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2577 Grade Road Falling Waters West Virginia 25419				
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 1/31/2007	20c. Location - City or Town, State Smithsburg, Maryland				
		21. Signature of Funeral Service Licensee S. Mark Sipp			22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA						Approximate Interval Between Onset and Death 2-3 days				
		b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): 4-5 years										
		c. Due to (or as a consequence of): 4-5 years										
		d. 4-5 years										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EREBEDO VASCULAR ACCIDENT, HYPERTENSION MULTI INFARCT DEMENTIA						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
		25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		24a. Was an autopsy performed? 1 Yes 2 No			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
		27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred				
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D18019						29d. Date signed (Month, Day, Year) JAN 29, 2007	
		29b. Signature and title of certifier DR. V. DATTA			29c. License number D18019							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. V. DATTA 340 MILL ST. HAL. MD 21740										
		31. Date filed (Month, Day, Year) FEB 01 2007			32. Registrar's Signature Patricia A. Speller							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 06179

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norma Ausmus					2. Date of Death Month 1 Day 30 Year 2007			3. Time of Death 07:16 M pm		
	4a. Facility Name (If not institution, give street and number) 167B Jamestown Rd.					4b. City, Town, or Location of Death Ocean City			4c. County of Death Worcester		
Funeral Director	5. Social Security Number 095-16-1227	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05 15 1923	9. Birthplace (State or Foreign Country) New York				
	Usual Residence of Decedent 10a. State MD 10b. County Worcester 10c. City, Town or Location Ocean City					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 167B Jamestown Rd.					10f. Zip Code 21842	10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: X			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Economist			16b. Kind of Business/Industry Federal Government				
	17. Father's Name (First, Middle, Last) Max Feller					18. Mother's Name (First, Middle, Maiden Surname) Mary Kreiger					
	19a. Informant's Name/Relationship (Type, Print) Nancy A. Morse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 167B Jamestown Rd. Ocean City, MD 21842			20c. Location - City or Town, State Hurlock				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran's			Date 02 05 07	20c. Location - City or Town, State Hurlock			
	21. Signature of Funeral Service Licensee M. Feller Butage					22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811					
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death years					
	a. Due to (or as a consequence of): Cardiomyopathy										
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. failure to thrive atrial fibrillation renal insufficiency					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
						28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier Kristine M. Skippin, MD				29c. License number D0059945	29d. Date signed (Month, Day, Year) 1-31-07
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33195 Lighthouse Road, Suite 6, Selbyville, DE 19975										
BA12	31. Date filed (Month, Day, Year) JAN 31 2007			32. Registrar's Signature James B. Foster							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04180

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Harvey Artrip II					2. Date of Death Month Day Year January 23, 2007	3. Time of Death 0929 M		
	4a. Facility Name (If not institution, give street and number) 36344 Old Ocean City Road			4b. City, Town, or Location of Death Willards		4c. County of Death Wicomico			
Funeral Director	5. Social Security Number 133-40-0997	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8/1/1950	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent 10a. State Maryland			10b. County Wicomico			10c. City, Town or Location Willards		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 36344 Old Ocean City Road				10f. Zip Code 21874		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 9		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter			16b. Kind of Business/Industry Painting			
17. Father's Name (First, Middle, Last) Ark Artrip				18. Mother's Name (First, Middle, Maiden Surname) Edith Sykes					
19a. Informant's Name/Relationship (Type, Print) Debora Ann Artrip/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36344 Old Ocean City Rd., Willards, MD 21874					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) CFSP		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 1/26/2007	20c. Location - City or Town, State Salisbury, MD				
21. Signature of Funeral Service Licensee David A. Thompson CFSP		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multisystem Organ Failure Due to (or as a consequence of): Chronic pancreatitis Due to (or as a consequence of): Chronic Insulin Dependent Diabetes Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 1/25/07		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1001 Philadelphia Ave, Ocean City, MD					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Jason Clem MD		29c. License number D0058701		29d. Date signed (Month, Day, Year) 1/25/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Clem MD		31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature James X. Brink		33. Date signed (Month, Day, Year)			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 181

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIOLET KATHLEEN BURT							2. Date of Death Month January	3. Time of Death Day Year 28, 2007			
	4a. Facility Name (If not institution, give street and number) Dove House				4b. City, Town, or Location of Death Westminister			4c. County of Death Carroll				
Funeral Director	5. Social Security Number 473-30-1823		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months If Under 24 Hrs. Days Hours Min.		8. Date of Birth (Month, Day, Year) May 30, 1928		9. Birthplace (State or Foreign Country) England	
	Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Riverdale			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5806 Quintana Street				10f. Zip Code 20737			10g. Citizen of What Country? England				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White				
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Frederick Percy Jenkins				18. Mother's Name (First, Middle, Maiden Surname) Bessie Elizabeth Symes							
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Janet M. Burt - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Playground Dr, Reading, PA 19611-1526							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation, 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 2/2/2007		20c. Location - City or Town, State Brentwood, Maryland					
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home, P.A.				4739 Baltimore Ave. Hyattsville, MD 20781			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				b. Due to (or as a consequence of): Breast Cancer				Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospital										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred Inhaler				
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 										
29c. License number D64983		29d. Date signed (Month, Day, Year) Jan. 29, 2007										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kashif Firozvi 2101 Medical Park Dr, Ste 200, Silver Spring, MD 20902		31. Date filed (Month, Day, Year) JAN 31 2007										
32. Registrar's Signature 												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar Amend #18, Per FHPGC 1-31-07 cr

2007 04 182
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death				
	CHARLOTTE E. BAYLOR							JAN 30 2007	4:50 AM				
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death					
	14400 HOME CREST APT 226 SILVER SPRING							MONTGOMERY					
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)					
	579349771		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	91 Yrs.			JULY 24 1915	PA.					
Usual Residence of Decedent													
10a. State	10b. County		10c. City, Town or Location						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
MD	MONTGOMERY		SILVER SPRINGS										
10e. Street and Number						10f. Zip Code	10g. Citizen of What Country?						
14400 HOME CREST RD. #226					20902		USA						
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK .						
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry DISTRICT COURT JUDGE					
Elementary/Secondary (0-12) 12 YRS	College (1-4 or 5+) 2 YRS.			ADMINISTRATOR.									
17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname) HALLYE PALMER HALLYE PALMER.							
19a. Informant's Name/Relationship (Type, Print) DAVID A BAYLOR ISON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1864 VISTA DE ORO AVE LOS ANGELES CA 90043									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) FT. LINCOLN			Date		20c. Location - City or Town, State BRENTWOOD MD.							
21. Signature of Funeral Service Licensee David Sull				22. Name and Address of Facility SATIN TRIMES FUNERAL HOME INC 3015-12TH ST NW WASH DC 20012									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A CLUE LEUKEMIA										Approximate Interval Between Onset and Death 1 MONTH			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
<p>a. Due to (or as a consequence of): A CLUE LEUKEMIA</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier Onelaw		29c. License number 033224						29d. Date signed (Month, Day, Year) JANUARY 31, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 FOREST GLEN RD #435, SILVER SPRING MD 20910													
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Janet A. Goode											

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 183

1. For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD LEE BRADFORD II					2. Date of Death Month Day Year January 25, 2007	3. Time of Death 1915 hrs	
	4a. Facility Name (if not institution, give street and number) 1770 Tucker Road					4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 578-13-2520	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 25 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24Hrs Hours Min.	8. Date of Birth (MM/DD/YYYY) JUNE 27, 1981		9. Birthplace (State or Foreign Country) CALIFORNIA	
	Usual Residence of Decedent 10a. State MD 10b. County PRINCE GEORGES 10c. City, Town or Location CAMP SPRINGS					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5615 LEON STREET			10f. Zip Code 20746	10g. Citizen of What Country? U.S.A			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE SUPPORT SPEC.			16b. Kind of Business/Industry IAP WORLD SERVICES		
17. Father's Name (First, Middle, Last) DONALD L. BRADFORD				18 Mother's Name (First, Middle, Maiden Surname) DENISE TRAMBLE				
19a. Informant's Name/Relationship (Type, Print) CHARLES W. PIERCE/STEPFATHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5615 LEON ST. CAMP SPRINGS, MD 20746				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: RESURRECTION CEMETERY				Date 2/1/07	20c. Location - City or Town, State CLINTON, MD			
21. Signature of Funeral Service Licensee Kenneth J. Stowact.				22. Name and Address of Facility STRICKLAND FUNERAL SERVICES, P.A. 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED						Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Jan 25, 2007	28b. Time of Injury 1857 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Driver auto auto collision			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway								
28f. Location (Street and Number or Rural Route Number, City or Town, State) 1770 Tucker road, Fort Washington, Md.								
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Mary G. Ripple MD. Deputy Chief Medical Examiner				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 27, 2007		
30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201								
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 184
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIVIAN BIGELOW							2. Date of Death Month Day Year JANUARY 27, 2007	3. Time of Death 12:30 PM		
	4a. Facility Name (If not institution, give street and number) 15210 ELKRIDGE WAY			4b. City, Town, or Location of Death SILVER SPRING			4c. County of Death MONTGOMERY				
Funeral Director	5. Social Security Number 148-07-3701	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 03.11.1919	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Silver Spring								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 15210 Elkridge Way				10f. Zip Code 20906			10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker				16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) Myer Fagan					18. Mother's Name (First, Middle, Maiden Surname) Rose Greenfeld						
19a. Informant's Name/Relationship (Type, Print) Buddy Hirsch-son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Woodedge Road, Silver Spring, MD 20906							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MT. Lebanon Cemetery				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 1.30.2007	20c. Location - City or Town, State Adelphi, MD				
21. Signature of Funeral Service Licensee John Williams				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure									Approximate Interval Between Onset and Death 1 year		
<p>a. Due to (or as a consequence of): Congestive Heart Failure</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
Atrial Fibrillation									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Renal Insufficiency									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier 		29c. License number D43202							29d. Date signed (Month, Day, Year) January 29, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charlene Blankford 3305 North Leisure World Blvd., Silver Spring, MD 20906											
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 									

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

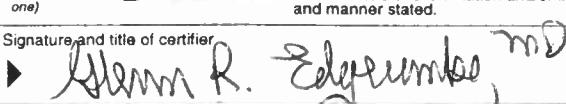
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 186

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Butler				2. Date of Death Month Day Year January 28, 2007		3. Time of Death 5:50 AM
	4a. Facility Name (If not institution, give street and number) Future Care Pineview				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 217-34-0227	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/28/1936	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent 10a. State Maryland 10b. County Charles 10c. City, Town or Location Indian Head 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number 3386 Lox Street				10f. Zip Code 20640		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Crew Cheif		16b. Kind of Business/Industry WSSC	
17. Father's Name (First, Middle, Last) William				18. Mother's Name (First, Middle, Maiden Surname) Thomas Mary Agnes Proctor			
19a. Informant's Name/Relationship (Type, Print) Josephine Butler/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3386 Lox St Indian Head, Maryland 20640		19c. Date	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd Aquasco, Maryland 20608			
23a. Part I. Enter the disease, or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of): Chronic Renal Failure</p> <p>b. Due to (or as a consequence of): Hypertension</p> <p>c. Due to (or as a consequence of): Diabetes mellitus</p> <p>d. Due to (or as a consequence of): Hypercholesterolemia</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. previous R sided stroke							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D23826		29d. Date signed (Month, Day, Year) 1-29-07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn R Edgecombe, MD 7700 Old Branch Ave, Clinton, Md. 20735							
31. Date filed (Month, Day, Year) JAN 31 2007				32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

07-00564

UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007-34187

1- For State
RegistrarPhysician/
Medical ExaminerFuneral
Director

Baltimore, MD 21215-0036
 Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23 or 28-f show any
 injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral DirectorPhysician
/Medical
Examiner**Medical Certification: To Be Completed by Physician/Medical Examiner**Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executedwithin 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last)

Jerrell Eugene Bodie

2. Date of Death
Month Day Year
January 20, 20073. Time of Death
2029 hrs4a. Facility Name (if not institution, give street and number)
Prince George's Hospital Center4b. City, Town, or Location of Death
Cheverly4c. County of Death
Prince George's

5. Social Security Number

263-82-1092

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

April 26, 1950

9. Birthplace (State or
Foreign Country)

FL

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

311 Laurel Ave.

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Richard Bodie

18. Mother's Name (First, Middle, Maiden Surname)

Ena Ferguson

19a. Informant's Name/Relationship (Type, Print)

Jeaneen M. Bodie/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7911 Sausalito Place Alexandria, VA 22309

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State4 Donation 5 Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Chesapeake Crematory

01/30/07

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte

22. Name and Address of Facility

Going Home Cremation Service
Beverly L. Heckrotte, P.A. POB 784 Clarksville

MO1251

Approximate Interval Between Onset and Death

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy4 Pregnant at time of death 5 Other (Specify)9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown1 Yes 2 No

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26 Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4 Nursing Home 5 Residence 6 Other1 Inpatient 2 ER/Outpatient 3 DOA4

VOID

CERTIFICATE #

2007 - 04188

SEE

CERTIFICATE #

2006 - 43471

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 04 189

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY A CARR						2. Date of Death Month Day Year JAN 26 2007	3. Time of Death 3:00 a M
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-62-7239		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Apr. 18, 1945	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent		10a. State MD 10b. County Prince Georges 10c. City, Town or Location Hyattsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 3900 Hamilton St. #K-101			10f. Zip Code 20781			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fraud Specialist			16b. Kind of Business/Industry Riggs Bank		
17. Father's Name (First, Middle, Last) Willie M. Petty				18. Mother's Name (First, Middle, Maiden Surname) Hester Irene Young				
19a. Informant's Name/Relationship (Type, Print) Marion E. Carr-Johnson/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2246 Brightseat Rd. #302 Landover, Md. 20785				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ft. Lincoln			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date 2-2-2007	20c. Location - City or Town, State Brentwood, MD.	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. Due to (or as a consequence of): ATHROSCLEROTIC HEART DISEASE</p> <p>b. Due to (or as a consequence of): HYPERTENSION</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>								
Approximate Interval Between Onset and Death								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown Other (Specify) _____						23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> EP/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0048083						
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 01/26/2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. IRVING WESTNEY 7610 Carroll Ave. Takoma Park, MD. 20902								
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04190

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Annette Credle</i>				2. Date of Death Month 01 Day 20 Year 07	3. Time of Death 1 A M	
	4a. Facility Name (If not institution, give street and number) Manor Care - Bethesda		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-60-6254	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/19/1910	9. Birthplace (State or Foreign Country) DC
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Montgomery				10c. City, Town or Location Bethesda		
	10e. Street and Number 6530 Democracy Boulevard		10f. Zip Code 20817		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4	16b. Kind of Business/Industry Clerk				
	17. Father's Name (First, Middle, Last) Charles Dixon Sidney				18. Mother's Name (First, Middle, Maiden Surname) Annette Montigue Brown Sidney		
	19a. Informant's Name/Relationship (Type, Print) Niece Jacqueline Blakely Wright				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1278 Hamburg Court; Waxham, NC 28173		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial	Date 01/27/2007	20c. Location - City or Town, State Suitland, MD			
	21. Signature of Funeral Service Licensee <i>Ralph Williams</i>				22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., N.W. Washington, DC 20011		
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <i>Atherosclerotic Heart disease.</i>		
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. Due to (or as a consequence of): <i>Pneumonia</i></p> <p>b. Due to (or as a consequence of): <i>Renal failure</i></p> <p>c. Due to (or as a consequence of): <i>Atrial fibrillation</i></p> <p>d. Due to (or as a consequence of):</p>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Colon Cancer</i> <i>Hypertension</i> <i>Arthritis</i>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29d. Date signed (Month, Day, Year) Jan. 25 2007		
	29b. Signature and title of certifier <i>Jay Gandy, MD</i>				29c. License number D53691		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Asian Jeremy, 6300 Democracy Blvd, Bethesda, MD</i>				31. Date filed (Month, Day, Year) JAN 30 2007		
	32. Registrar's Signature <i>Barbara L. Spangler</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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10

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 191

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernestine Grey Cordes							2. Date of Death Month JAN Day 31 Year 2007	3. Time of Death 12:13 PM		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington County			
Funeral Director	5. Social Security Number 236-72-2247		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Dec 23 1946	9. Birthplace (State or Foreign Country) West Virginia			
	Usual Residence of Decedent Maryland		10a. State Maryland 10b. County Washington		10c. City, Town or Location Hagerstown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 82 Manor Drive Apt 101				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1950-1953	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Personal Residence						
	17. Father's Name (First, Middle, Last) Fred Small				18. Mother's Name (First, Middle, Maiden Surname) Ernestine Pritt Small						
	19a. Informant's Name/Relationship (Type, Print) Kelly N. Cordes (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Highland Ave Apt. 310 Hagerstown Maryland 21740						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Smithsburg Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory	Date 2-2-2007	20c. Location - City or Town, State Smithsburg Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sep ticonia								Approximate Interval Between Onset and Death weeks		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia										
	b. COPD								years		
	c. Due to (or as a consequence of): Acute Renal Failure										
	d. Due to (or as a consequence of): Disseminated Intravascular Coagulopathy										
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure Disseminated Intravascular Coagulopathy Thrombocytopenia, Terminal, Extensive									23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 			29c. License number D 00 47556			29d. Date signed (Month, Day, Year) 01-31-07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. JOHNSON MD, 1136 ORAL COURT, HAGERSTOWN MD 21740										
	31. Date filed (Month, Day, Year) FEB 01 2007			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04192

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Carol Ann Cramer						2. Date of Death Month Day Year January 30, 2007	3. Time of Death 1030 hrs
	4a. Facility Name (if not institution, give street and number) 20014 Rosebank Way Apt 130			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington	
Funeral Director	5. Social Security Number 217-32-6021	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24hrs Days Hours Min.	8. Date of Birth (MM/DD/YYYY) August 20 1936	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland 10b. County Washington 10c. City, Town or Location Hagerstown						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 20014 Rosebank Way			10f. Zip Code 21742			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify: White	
Physician/ Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Personal Residence	
	17. Father's Name (First, Middle, Last) Paul M. Butts			18. Mother's Name (First, Middle, Maiden Surname) Marie McKee Butts				
Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jo P. Staley (sister)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4338 Harney Road Taneytown Maryland 21787				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: Smithsburg Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory			Date 2-1-2007	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Douglas A. Fiery			22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. c. d.			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED						
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier Patricia Aronica-Pollak MD		29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) January 31, 2007			
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
31. Date filed (Month, Day, Year) EBR 01 2007		32. Registrar's Signature [Signature]			ORIGINAL			

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

BH-2

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 193

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Terry Allen Crews							2. Date of Death Month Day Year Jan. 25, 2007	3. Time of Death 1:05 PM		
	4a. Facility Name (If not institution, give street and number) SALISBURY REHAB. & NURSING CENTER				4b. City, Town, or Location of Death SALISBURY, MD.			4c. County of Death WICOMICO			
Funeral Director	5. Social Security Number 244-44-6142	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. 	8. Date of Birth (Month, Day, Year) 11/29/1929	9. Birthplace (State or Foreign Country) North Carolina				
	Usual Residence of Decedent 10a. State Maryland 10b. County Wicomico 10c. City, Town or Location Salisbury							10d. Inside City Limits 1 Yes 2 No			
10e. Street and Number 1704 East Gate Dr.				10f. Zip Code 21804			10g. Citizen of What Country? USA				
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Truck Driver		16b. Kind of Business/Industry Trucking							
17. Father's Name (First, Middle, Last) Paul Crews				18. Mother's Name (First, Middle, Maiden Surname) Margaret Walters							
19a. Informant's Name/Relationship (Type, Print) Keith A. Crews/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11313 Snethen Church Rd., Mardela Springs, MD 21837							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory			Date 1/26/07	20c. Location - City or Town, State Salisbury, MD					
21. Signature of Funeral Service Licensee H. Thompson CFSP				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804							
<p>23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) Lung Cancer</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Lung Cancer Due to (or as a consequence of): years</p> <p>b. Chronic obstructive pulmonary disease Due to (or as a consequence of): years</p> <p>c. _____ Due to (or as a consequence of): _____</p> <p>d. _____ Due to (or as a consequence of): _____</p>									Approximate Interval Between Onset and Death years		
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p>									23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
<p>25. Was case referred to medical examiner? 1 Yes 2 No</p> <p>26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)</p>									24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
<p>27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</p> <p>28a. Date of Injury (Month, Day Year) </p> <p>28b. Time of Injury M</p> <p>28c. Injury at Work? 1 Yes 2 No</p> <p>28d. Describe how injury occurred</p>									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 		28f. Location (Street and Number or Rural Route Number, City or Town, State)
<p>29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier William Robins, M.D.</p>									29c. License number 028349	29d. Date signed (Month, Day, Year) 1/25/07	
<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804</p>											
31. Date filed (Month, Day, Year) JAN 29 2007				32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04194

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) ROBERT LEROY CALLOWAY							2. Date of Death Month Day Year January 23 2007	3. Time of Death P 23:00 M		
4a. Facility Name (If not institution, give street and number) <i>Pensacola Regional Medical Center</i>				4b. City, Town, or Location of Death <i>SALISBURY</i>			4c. County of Death <i>Wicomico</i>			
5. Social Security Number 221-20-8461		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 15, 1935	9. Birthplace (State or Foreign Country) DELAWARE			
Usual Residence of Decedent 10a. State DELAWARE 10b. County SUSSEX 10c. City, Town or Location SEAFORD										
10e. Street and Number 9503 WILSON AVENUE				10f. Zip Code 19973			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) DOCK FOREMAN			16b. Kind of Business/Industry INDUSTRIAL MANUFACTURING			
17. Father's Name (First, Middle, Last) JAMES CARLTON CALLOWAY					18. Mother's Name (First, Middle, Maiden Surname) HELEN HASTINGS					
19a. Informant's Name/Relationship (Type, Print) CATHERINE LYNN PENNINGTON/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 292 STAYTONVILLE ROAD, HARRINGTON, DE 19952						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BRIDGEVILLE CEMETERY			Date 01/29/2007	20c. Location - City or Town, State BRIDGEVILLE, DELAWARE		
21. Signature of Funeral Service Licensee <i>D. Julian</i>				22. Name and Address of Facility PARSELL FUNERAL HOMES & CREMATORIUM, HARDESTY CHAPEL 202 LAWS STREET, BRIDGEVILLE, DELAWARE 19933						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Sequentially list conditions, if any leading to final death cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory Failure Arteric Valve disease Coronary artery disease									Approximate Interval Between Onset and Death 3 days 1 week 2 years 3 years	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>J. Julian MD</i>					29c. License number 141813	29d. Date signed (Month, Day, Year) 1-24-07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Julian, MD 201 Pine Bluff Rd Salisbury, MD 21801				32. Registrar's Signature <i>James B. Julian</i>						
31. Date filed (Month, Day, Year) JAN 29 2007				33. Original						

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 195

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>William Cordrey</i>		01 24 2007		1725 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Coastal Hospice At the Lake</i>		<i>Salisbury</i>		<i>Wicomico</i>
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/11/1931
222-18-4797				9. Birthplace (State or Foreign Country) Delaware
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury		
10e. Street and Number 671 North Park Drive		10f. Zip Code 21804		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) - Supervisor		16b. Kind of Business/Industry DuPont Textile Co.
17. Father's Name (First, Middle, Last) Harry James Cordrey			18. Mother's Name (First, Middle, Maiden Surname) Lida Helen Ward	
19a. Informant's Name/Relationship (Type, Print) Wm. Cordrey Jr./son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 95 Freeman Rd., Oxford, CT 06478		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Salisbury Crematory</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 1/25/07
21. Nature of Funeral Service Licensee <i>David H. Thompson CFSP</i>		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>Metastatic Pancreatic Cancer</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of): <i>Metastatic Pancreatic Cancer</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>		
		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
		<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>David E. Cordrey MD</i>		29c. License number 026278		29d. Date signed (Month, Day, Year) 1-25-07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David E. Cordrey Coastal Hospice po box 1733 Salisbury MD 21802		32. Registrar's Signature <i>Karen L. Aguirre</i>		
31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature		

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 196

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

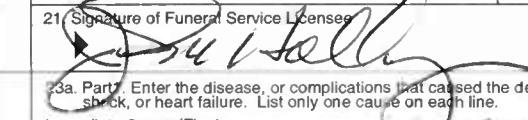
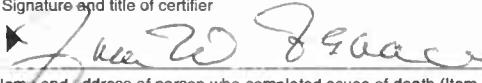
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		Oscar Carey		2. Date of Death	Month 01 Day 27 Year 07	3. Time of Death 0820 AM		
4. Facility Name (If not institution, give street and number)		Coastal Hospice at the Lake		4b. City, Town, or Location of Death Salisbury		4c. County of Death WICOMICO		
5. Social Security Number 216-14-2441		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 4/1/1924	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent		10a. State Maryland		10b. County Wicomico			10c. City, Town or Location Salisbury	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 706 Riverside Pines Court				10f. Zip Code 21801			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Navy		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		President			16b. Kind of Business/Industry Real Estate Developer	
17. Father's Name (First, Middle, Last) Oscar Ashton Carey				18. Mother's Name (First, Middle, Maiden Surname) Lilly Dykes				
19a. Informant's Name/Relationship (Type, Print) Susan Evans/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 W. Jones Station Rd., Severna Park, MD 21146				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery		Date 1/31/07		20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
33a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				33b. Approximate Interval Between Onset and Death ORGANIC BRAIN SYNDROME				
33c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{		33d. Due to (or as a consequence of): RENAL FAILURE				
33e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		33f. 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		33g. 23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				33h. 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred	
29a. Certifier (Check only one) 		Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier 		29c. License number D14256		29d. Date signed (Month, Day, Year) 1/27/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEERSHEAD HOSPITAL SALTSBURY MD 21801								
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

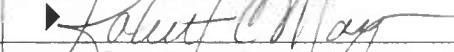
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04197

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARJORIE C. DuPONT							2. Date of Death Month Day Year January 27, 2007	3. Time of Death 10:30 p ^M	
	4a. Facility Name (If not institution, give street and number) 7016 Hunter Lane			4b. City, Town, or Location of Death Hyattsville			4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 069-09-9447	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 11-19-1916	9. Birthplace (State or Foreign Country) New York	
Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Hyattsville 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 7016 Hunter Lane				10f. Zip Code 20782			10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Secretary			Education		
17. Father's Name (First, Middle, Last) William Cosgriff					18. Mother's Name (First, Middle, Maiden Surname) Helene Joynt					
19a. Informant's Name/Relationship (Type, Print) Anne Scott - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7016 Hunter Lane, Hyattsville, Maryland 20782					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. Peter's Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter's Cemetery			Date 2-3-2007	20c. Location - City or Town, State Rome, New York			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Approximate Interval Between Onset and Death 10 months										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerotic Heart Disease Years Years										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					
		28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D37934			29d. Date signed (Month, Day, Year) 1/29/2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Tritschler 110 7500 Greenway Ctr Dr Greenbelt MD 20770										
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For 2-1-07
State Registrar Amend#30. PerPhys. PGCcr Certificate of Death

Reg. No. 2007 04 198

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jerry Dickson							2. Date of Death Month Day Year January 26, 2007 19:20 PM	3. Time of Death							
	4a. Facility Name (If not institution, give street and number) Prince Georges Hosp Center Cheverly				4b. City, Town, or Location of Death Cheverly			4c. County of Death PG								
Funeral Director	5. Social Security Number 420-64-8651		6. Sex M	7. Age (In yrs. last birthday) 57	If Under 1 Year Months Yrs.	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 08/17/1949	9. Birthplace (State or Foreign Country) TN								
	Usual Residence of Decedent 10a. State MD 10b. County Prince Georges 10c. City, Town or Location Mitchellville 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
To Be Completed by Funeral Director	10e. Street and Number 1500 Brady Court				10f. Zip Code 20721			10g. Citizen of What Country? USA								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 4 years		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Police Officer			17. Father's Name (First, Middle, Last) Clarence Dixon 18. Mother's Name (First, Middle, Maiden Surname) Kathleen Lockett								
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marian Dickson/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Brady Court Mitchellville, MD 20721		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham Veteran	Date 02/01/2007	20c. Location - City or Town, State Cheltenham, MD						
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Janet C. Dickson		22. Name and Address of Facility Dunn & Sons 5635 Eads St. NE Washington DC 20018		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis			Approximate Interval Between Onset and Death								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Patient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year)			27b. Time of Injury 28b. Time of Injury			27c. Injury at Work? 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			27d. Describe how injury occurred 28d. Describe how injury occurred		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year)		28b. Time of Injury 28b. Time of Injury			28c. Injury at Work? 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred 28d. Describe how injury occurred					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D55220		29d. Date signed (Month, Day, Year) 1/26/07											
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hosp de Cheverly MD 20785		32. Registrar's Signature Lester M. Miles													
State Registrar	31. Date (Ind Month, Day) JAN 31 2007		32. Registrar's Signature Janet C. Dickson													

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

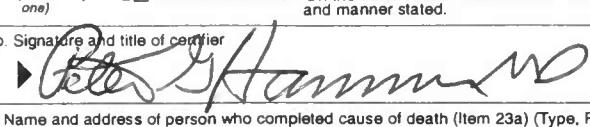
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 199

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur H. Fuldner, Jr.				2. Date of Death Month Day Year Jan. 28, 2007	3. Time of Death 9:22 PM	
	4a. Facility Name (If not institution, give street and number) 5108 Baltan Road		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 490-22-1592	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) Sept. 12, 1925	9. Birthplace (State or Foreign Country) Missouri	
	Usual Residence of Decedent 10a. State Md.		10b. County Montgomery		10c. City, Town or Location Bethesda		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 5108 Baltan Road			10f. Zip Code 20816		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer			16b. Kind of Business/Industry Engineer
	17. Father's Name (First, Middle, Last) Arthur H. Fuldner, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Emma Louise Schuermann		
	19a. Informant's Name/Relationship (Type, Print) Eileen M. Fuldner/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5108 Baltan Road, Bethesda, Md. 20816		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem		Date Feb. 1, 07	20c. Location - City or Town, State Silver Spring, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash., D.C. 20007		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Ischemic Cardiomyopathy Due to (or as a consequence of): c. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): d. Hypertension Approximate Interval Between Onset and Death Years						
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercholesterolemia Mitral Valve Replacement Chronic Kidney Disease 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier  29c. License number D32033 29d. Date signed (Month, Day, Year) January 29, 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter G. Hamm, M.D. 5530 Wisconsin Ave. #930 Chevy Chase, Maryland 20815						
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007	32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04200

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Garland Finlon				2. Date of Death Month January Day 28 , Year 2007	3. Time of Death 12:00 p M	
	4a. Facility Name (If not institution, give street and number) Hermitage at St. Johns Creek		4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 213-38-2609	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) July 28, 1909	9. Birthplace (State or Foreign Country) New York	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Calvert 10c. City, Town or Location Chesapeake Beach 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number 4010 15th Street		10f. Zip Code 20732		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) school teacher	16b. Kind of Business/Industry public school				
	17. Father's Name (First, Middle, Last) Allan Tasker Garland			18. Mother's Name (First, Middle, Maiden Surname) Olive Tipping			
	19a. Informant's Name/Relationship (Type, Print) Harold G. Finlon, son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4326 Overlook Cove Rd., Charlotte, NC 28216				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Cedar Hill Cemetery		Date 02/02/2007	20c. Location - City or Town, State Suitland, MD			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 						
	22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia						Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Anemia						
	a. Due to (or as a consequence of): UTI B12 deficiency						
	b. Due to (or as a consequence of): UTI						
	c. Due to (or as a consequence of):						
	d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ASSISTED Living				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 			29c. License number D 50290		29d. Date signed (Month, Day, Year) 1-31-07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Shul MD 110, Hosp RD Prince Fred MD 20678						
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

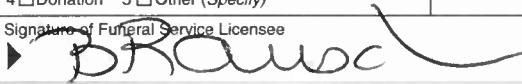
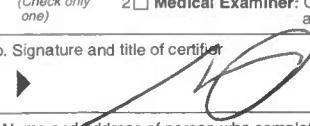
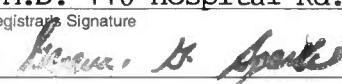
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ID

Certificate of Death

Reg. No. 2007 04 201

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stephen Fratz					2. Date of Death Month Day Year January 26, 2007	3. Time of Death M 5:15 P.	
	4a. Facility Name (If not institution, give street and number) 10951 Elm Drive			4b. City, Town, or Location of Death Lusby		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 220-92-9781	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 17 1965	9. Birthplace (State or Foreign Country) Connecticut	
	Usual Residence of Decedent			10c. City, Town or Location Lusby			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 10951 Elm Drive			10f. Zip Code 20657		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) diesel mechanic		16b. Kind of Business/Industry repair			
	17. Father's Name (First, Middle, Last) Ernest Fratz			18. Mother's Name (First, Middle, Maiden Surname) Fay O'Connor Marie O'Connor				
	19a. Informant's Name/Relationship (Type, Print) Dana Dove Fratz - wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11006 Elm Dr. Lusby, MD 20657				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John Vianney Feb 1 2007		Date 1	20c. Location - City or Town, State Prince Frederick MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Pancreatic Cancer						Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	a. Due to (or as a consequence of):  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number 033123		29d. Date signed (Month, Day, Year) 1-27-07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
	Jonathan Lowenthal, M.D. 110 Hospital Rd. Suite 310 Prince Frederick MD 20678							
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	31. Date filed (Month, Day, Year) JAN 30 2007	32. Registrar's Signature 						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04202

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS FOUNT				2. Date of Death Month 01 Day 26 Year 2007		3. Time of Death 1645 M		
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care-Spa Creek Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 232-16-0391	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months 05	If Under 24 Hrs. Days 02	8. Date of Birth (Month, Day, Year) 05/02/1919	9. Birthplace (State or Foreign Country) West Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Annapolis						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1612 Wood Tree Court West			10f. Zip Code 21409			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: X	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) Joel Pardue				18. Mother's Name (First, Middle, Maiden Surname) Mary Barlow				
	19a. Informant's Name/Relationship (Type, Print) Judy Myers/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Wood Tree Court West, Annapolis, MD 21409				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Cedar Bluff Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Bluff Cemetery		Date 01/31/2007	20c. Location - City or Town, State Annapolis, Maryland		
	21. Signature of Funeral Service Licensee ► [Signature]				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037				
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia b. Alzheimer Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 3 Days 10 years	
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Chief Medical Officer, Hospice of the Chesapeake				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, MD, 445 Defense Highway, Annapolis, MD 21401				29c. License number D 21438			29d. Date signed (Month, Day, Year) 01-26-07	
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature [Signature]			ORIGINAL			

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#17. PerfHPGC1-31-07cr Certificate of Death

Reg. No.

2007 01203

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

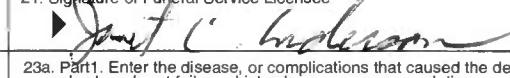
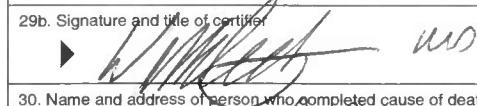
Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

1- For State Registrar Amend#17. PerfHPGC1-31-07cr Certificate of Death		2. Date of Death Month Day Year January 23, 2007	3. Time of Death 10:27 PM
1. Decedent's Name (First, Middle, Last) Joyce Marie Gatling		4a. Facility Name (If not institution, give street and number) Doctor's Hospital	
4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Georges	
5. Social Security Number 218-42-2233		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 66
8. Date of Birth (Month, Day, Year) July 5, 1940		9. Birthplace (State or Foreign Country) NC	
10a. State MD		10b. County Prince Georges	10c. City, Town or Location Glenn Dale
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 6918 Pine Valley Drive		10f. Zip Code 20769	
10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Conferencing	16b. Kind of Business/Industry Pentagon
17. Father's Name (First, Middle, Last) Fred Hunter		18. Mother's Name (First, Middle, Maiden Surname) Henrietta Thrope	
19a. Informant's Name/Relationship (Type, Print) Valareese M. Hillman		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 6918 Pine Valley Drive Glenn Dale MD 20769	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National	Date Jan. 30, 2007
21. Signature of Funeral Service Licensee 		20c. Location - City or Town, State Laurel, MD	
22. Name and Address of Facility Dunn & Sons 5635 Eads St. NE Washington, DC 20019			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 5 minutes	
a. Due to (or as a consequence of): Myocardial Infarction			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Congestive Heart Failure		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  William W. Boyce, M.D.	
29c. License number 047603		29d. Date signed (Month, Day, Year) 1/25/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William W. Boyce, M.D.		31. Date filed (Month, Day, Year) JAN 31 2007	
32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 204

1. For State
RegistrarPhysician/
Medical Examiner

		1. Decedent's Name (First, Middle, Last) James Edward Gregory				2. Date of Death Month Day Year February 1, 2007		3. Time of Death 1343 hrs	
		4a. Facility Name (if not institution, give street and number) 5795 Sheridan Point Road				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
5. Social Security Number 217-78-3998		6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) Sept 15, 1962	9. Birthplace (State or Foreign Country) Maryland		
10a. State Maryland		10b. County Calvert	10c. City, Town or Location Prince Frederick				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5795 Sheridan Point Road		10f. Zip Code 20678				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1981-1987		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White			14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HVAC Forman		16b. Kind of Business/Industry Heating and Air Conditioning					
17. Father's Name (First, Middle, Last) Edward Joseph Gregory, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Katherine Brown					
19a. Informant's Name/Relationship (Type, Print) Beverly A. Davis-Gregory (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5795 Sheridan Pt. Rd., Prince Frederick, MD 20678			Date 2/09/2007			20c. Location - City or Town, State Suitland, Maryland	
21. Signature of Funeral Service Licensee St. S. Bitt		22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Methadone and diazepam intoxication Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED #F3a,27,28a-f, per, ME, G865, 3/14/07 TT							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 2/1/2007		28b. Time of Injury FNd 1:25 am		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unk	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home						28f. Location (Street and Number or Rural Route Number, City or Town, State) 5795 Sheridan Point Rd. Prince Frederick, MD	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated									
29b. Signature and title of certifier Tasha Greenberg MD		29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) February 2, 2007			
30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner		111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) FEB 7 2007		32. Registrar's Signature Beverly A. Davis							

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 205

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death	3. Time of Death	
	Fern Elizabeth GILBERT						Month Day Year	4:00 p M	
Funeral Director	4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death	4c. County of Death	
	Julia Manor Nursing Home						Hagerstown	Washington	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)		
	216-14-3145	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	85 Yrs.	Months	Days	Hours Min.	March 24, 1921	Maryland	
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location						10d. Inside City Limits	
Maryland	Washington	Hagerstown						1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?	
241 Winding Oak Drive				21740				USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White	
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 12			College (1-4 or 5+) 0			Homemaker			Her own home
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
Thomas Henry Showe					Helen Burgan				
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Dale Gilbert - Son				P.O. Box 1016 Saco Maine 04072					
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Cedar Lawn Mem. Park			2/2/07	Hagerstown, Maryland	
21. Signature of Funeral Service Licensee				22. Name and Address of Facility					
				Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
Metastatic Colon Cancer									
Approximate Interval Between Onset and Death									
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Chronic Renal Disease									
Cardiomyopathy									
Diabetes Mellitus									
IF FEMALE:		23c. If yes, outcome of pregnancy						23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						Month Day Year	
23e. Did tobacco use contribute to the cause of death?									
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed?									
24b. Were autopsy findings available prior to completion of cause of death?									
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner?		26. Place of Death (Check only one)							
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one)		29b. Signature and title of certifier							
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29c. License number		29d. Date signed (Month, Day, Year)							
J060396		02/01/07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
Farid Munshi 1126 8th St Hagerstown, MD 21740									
31. Date filed (Month, Day, Year)		32. Registrar's Signature							
FEB 02 2007									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 206

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Fannie Virginia Gearhart					2. Date of Death Month Day Year January 30 2007	3. Time of Death Hour:Minute 2:16 PM	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital					4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington	
Funeral Director	5. Social Security Number 214-28-0456	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) Feb. 24 1931	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland 10b. County Washington 10c. City, Town or Location Maugansville					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 14011 Village Mill Drive			10f. Zip Code 21767	10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Presser		16b. Kind of Business/Industry Manufacturing			
	17. Father's Name (First, Middle, Last) Stuart Hilson Mason			18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Boppe				
	19a. Informant's Name/Relationship (Type, Print) Douglas Eugene Gearhart / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18610 Canteen Circle Hagerstown Maryland 21742				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Date 2/7/2007	20c. Location - City or Town, State Hagerstown Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Artherosclerotic Chronic Vascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
	23b. If Female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number 00056965			29d. Date signed (Month, Day, Year) January 30, 2007	
	29b. Signature and title of certifier 							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Kitch 251 E. Antietam Street Hagerstown, MD 21740							
Medical Certification: To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) FEb 01 2007	32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

SH-5

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

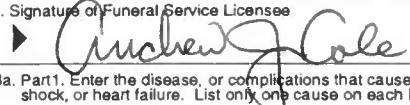
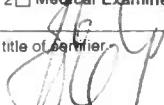
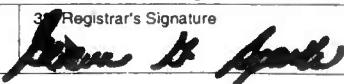
State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death

Reg. No.

2007 04207

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sally Ann Hite				2. Date of Death Month Day Year January 28, 2007	3. Time of Death 11:40 a M	
	4a. Facility Name (If not institution, give street and number) 4704 Topping Road		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 189-18-9880	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 16, 1921	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent Maryland Montgomery		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville
10e. Street and Number 4704 Topping Road			10f. Zip Code 20852			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) College (1-4 or 5+) 1		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify White		14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Technician			16b. Kind of Business/Industry U.S. Government	
17. Father's Name (First, Middle, Last) Peter Yeraska				18. Mother's Name (First, Middle, Maiden Surname) Rose Straigis			
19a. Informant's Name/Relationship (Type, Print) Robert Hite/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10652 Whiterock Court, Laurel, MD 20707				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			Date Jan. 31, 2007	20c. Location - City or Town, State Silver Spring, Maryland
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. Metastatic Carcinoma of Unknown Source Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of Certifier 				29c. License number D16495		29d. Date signed (Month, Day, Year) January 29, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joel Goozh, M.D. 6410 Rockledge Drive, Bethesda, MD 20817							
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event. **Medical Examiner must be notified once.**

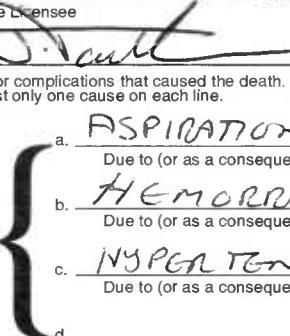
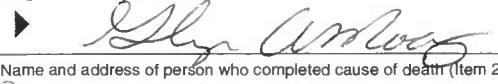
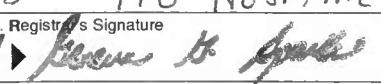
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04208

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dexter Lane Hash							2. Date of Death Month Day Year January 27, 2007	3. Time of Death 11:25 a M	
	4a. Facility Name (If not institution, give street and number) Calvert County Nursing Center				4b. City, Town, or Location of Death Prince Frederick			4c. County of Death Calvert		
Funeral Director	5. Social Security Number 577-10-0693		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct. 13, 1909	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent		10a. State VA		10b. County Arlington		10c. City, Town or Location Arlington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 6134 North 36th Street				10f. Zip Code 22213			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 5		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanic			16b. Kind of Business/Industry refridgeration		
	17. Father's Name (First, Middle, Last) John Samuel Hash				18. Mother's Name (First, Middle, Maiden Surname) Minnie Whitlow					
	19a. Informant's Name/Relationship (Type, Print) Rosemary C. Purnell, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Dogwood Lane, Owings, MD 20736					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 				20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery			Date 01/31/2007		
								20c. Location - City or Town, State Washington, DC		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, P.A.					
								23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA							Approximate Interval Between Onset and Death		
	Due to (or as a consequence of): b. HEMORRAGIC STROKE									
	Due to (or as a consequence of): c. HYPER TENSION									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number 050233			29d. Date signed (Month, Day, Year) 01/29/2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glynis A. Mord, MD 110 NOSRML DR, SUITE 310, PRINCE FREDERICK 20678									
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 209

1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

George Daniel Harbin, Jr.

2. Date of Death

Month Day Year

3. Time of Death

11:50 A.M.

January 26, 2007

4c. County of Death

Calvert

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

Funeral
Director

5. Social Security Number

577-40-3461

6. Sex

M

F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 4, 1930

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Port Republic

10d. Inside City Limits

Yes No

10e. Street and Number

2750 Scientists Cliffs Road

10f. Zip Code

20676

10g. Citizen of What Country?

United States

To Be Completed by Funeral Director

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Interior Designer

16b. Kind of Business/Industry

Commerical Business

17. Father's Name (First, Middle, Last)

George Daniel Harbin, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Katie Rankin

19a. Informant's Name/Relationship (Type, Print)

Bob Jones (Personal Representative) 2750 Scientists Cliffs Rd, Port Republic, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20676

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 1/29/07

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, P.A.

4405 Broomes Island Road, Port Republic, Maryland 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

a. Due to (or as a consequence of):

5 years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No

9 Unknown

23c. If yes, outcome pf pregnancy

Live birth Fetal death
 Pregnant at time of death Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital:

Inpatient

ER/Outpatient

DOA

26. Place of Death (Check only one)

Nursing Home

Residence

Other (Specify)

27. Manner of Death

Natural

Accident

Suicide

Homicide

Pending investigation

Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

PW6314

29d. Date signed (Month, Day, Year)

1/27/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul V. Pomilla, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

JAN 30 2007

32. Registrar's Signature

6t1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04210

1- For
State
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Jane Hurst							2. Date of Death Month Day Year January 27, 2007	3. Time of Death 5:09 P.M.
	4a. Facility Name (If not institution, give street and number) Rockville Nursing Home			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 168-56-9608	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug. 11, 1915	9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Germantown								
	10e. Street and Number 22700 Ridge Road			10f. Zip Code 20876			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) William George Davis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Annie Radford				
	19a. Informant's Name/Relationship (Type, Print) Linda New / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22700 Ridge Road, Germantown, Maryland 20876				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Irwin Union Cemetery		Date 2/3/07	20c. Location - City or Town, State Irwin, Pennsylvania			
	21. Signature of Funeral Service Licensee Heather M. Hoff				22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dementia								
	Approximate Interval Between Onset and Death years								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Steven Dolinsky								
	29c. License number D-20148								
	29d. Date signed (Month, Day, Year) January 29 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky 911 Russell Ave, Gaithersburg Md.								
	31. Date filed (Month, Day, Year) JAN 30 2007								
	32. Registrar's Signature Steven Dolinsky								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar		Amend # 4c per Phys/FH 01-30-2007 CNM "Remove"		Reg. No. 2007 0121	
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>MARGARET Louise HERBERT</i>		2. Date of Death Month January Day 27 Year 2007	
Funeral Director		4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital of Baltimore</i>		3. Time of Death 3:13A M	
		4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>FREDERICK</i>	
		5. Social Security Number <i>215-34-2971</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	
		8. If Under 1 Year Months Days		9. If Under 24 Hrs. Hours Min.	
		10. Date of Birth (Month, Day, Year) <i>June 1, 1939</i>		11. Birthplace (State or Foreign Country) <i>ENGLAND</i>	
		10a. State <i>MD.</i>		10b. County <i>FREDERICK</i>	
		10c. City, Town or Location <i>FREDERICK</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <i>105 PENNSYLVANIA Ave.</i>		10f. Zip Code <i>21701</i>	
		10g. Citizen of What Country? <i>U.S.A.</i>			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>34 yrs</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>
		15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nursing Technician</i>	16b. Kind of Business/Industry <i>MEDICAL OFFICE</i>	
		17. Father's Name (First, Middle, Last) <i>Thomas E. Naylor</i>	18. Mother's Name (First, Middle, Maiden Surname) <i>NETTIE OVERS</i>		
		19a. Informant's Name/Relationship (Type, Print) <i>Samuel J. HERBERT</i>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>105 Pennsylvania Ave. Fred. MD. 21701</i>		
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>GARY L. ROLLINS FUNERAL HOME</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ST. PAUL AVE CEMETERY</i>	Date <i>Feb. 1, 2007</i>	
		21. Signature of Funeral Service Licensee <i>GARY L. ROLLINS</i>	22. Name and Address of Facility <i>110 W. South St. Fred. MD. 21701</i>	20c. Location - City or Town, State <i>DELES</i>	
		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Acute Myocardial Infarct</i> Approximate Interval Between Onset and Death <i>1 day</i>			
		a. Due to (or as a consequence of): <i>Coronary Endocarditis</i> Approximate Interval Between Onset and Death <i>1 day</i>	b. Due to (or as a consequence of): <i>Coronary Endocarditis</i> Approximate Interval Between Onset and Death <i>1 day</i>	c. Due to (or as a consequence of): <i>Coronary Endocarditis</i> Approximate Interval Between Onset and Death <i>1 day</i>	
		d. Due to (or as a consequence of): <i>Coronary Endocarditis</i> Approximate Interval Between Onset and Death <i>1 day</i>			
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Endometrial Carcinoma - Advanced Intraluminal Adenoma of Cervix</i>			
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		23g. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			
		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
		29b. Signature and title of certifier <i>Norma Snell MD</i>			
		29c. License number <i>00029633</i>			
		29d. Date signed (Month, Day, Year) <i>January 27, 2007</i>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Norma Snell, MD</i>			
		31. Date filed (Month, Day, Year) <i>JAN 30 2007</i>			
		32. Registrar's Signature <i>Barbara B. Aponte</i>			

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01212

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Starritt Holmes					2. Date of Death Month Day Year January 25 2007	3. Time of Death 6:30 A M		
	4a. Facility Name (If not institution, give street and number) Lorien Life Center					4b. City, Town, or Location of Death Mount Airy	4c. County of Death Carroll		
Funeral Director	5. Social Security Number 217-12-2202	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 18, 1912	9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland					10b. County Carroll	10c. City, Town or Location Mt. Airy	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 713 Midway Avenue					10f. Zip Code 21771	10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator			16b. Kind of Business/Industry Tire Service		
	17. Father's Name (First, Middle, Last) George Pemberton Holmes					18. Mother's Name (First, Middle, Maiden Surname) Alice Williams			
	19a. Informant's Name/Relationship (Type. Print) L. Patrick Holmes / Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7831 Emerson Burrier Road Mt. Airy, Maryland 21771			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery	Date January 29, 2007	20c. Location - City or Town, State Mt. Airy, Maryland	
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death			
	<p>a. Congestive Heart Failure Due to (or as a consequence of):</p> <p>b. Ischemic Cardiomyopathy Due to (or as a consequence of):</p> <p>c. Coronary Artery Disease Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown					23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Anemia					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	Chronic Renal Insufficiency					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number D35965			29d. Date signed (Month, Day, Year) January 26, 2007
	29b. Signature and title of certifier 								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David B. Harding, M.D. 602 Center Street Mt. Airy, Maryland 21771								
	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JS

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 21 3

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at once.

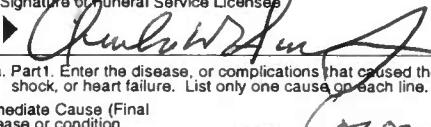
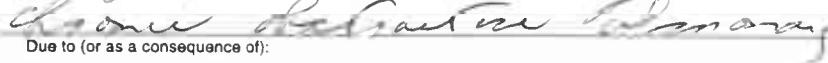
Edna Hudson

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	EDNA J. HUDSON			2. Date of Death Month Day Year	3. Time of Death			
Salisbury Rehab & Nursing			Salisbury		Jan. 24 2007 9:40 AM			
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death			
5. Social Security Number			6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month Day, Year) JULY 28, 1926	9. Birthplace (State or Foreign Country) PENNSYLVANIA		
Usual Residence of Decedent			10a. State DELAWARE			10b. County SUSSEX	10c. City, Town or Location SELBYVILLE	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 37107 HUDSON ROAD			10f. Zip Code 19975			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) OFFICE MANAGER			16b. Kind of Business/Industry AUTO SERVICE		
17. Father's Name (First, Middle, Last) JOHN RICKARDS			18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH WARDEN					
19a. Informant's Name/Relationship (Type, Print) LINDA M. COFFIN/DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7444 MARKET ST., WILLARDS, MARYLAND 21874					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ST. GEORGE'S CEMETERY			Date 1/30/07	20c. Location - City or Town, State CLARKSVILLE, DELAWARE	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death years					
a.  Due to (or as a consequence of):								
b.  Due to (or as a consequence of):								
c.  Due to (or as a consequence of):								
d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number 029349			29d. Date signed (Month, Day, Year) 4/24/07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, M.D. 200 Civic Ave. Salisbury, MD 21804			32. Registrar's Signature 					
31. Date filed (Month, Day, Year) JAN 29 2007			33. Date signed (Month, Day, Year)					

ORIGINAL

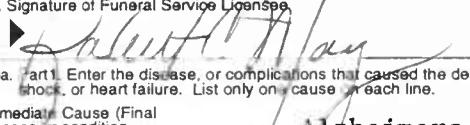
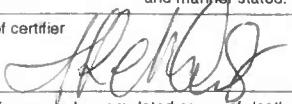
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 214
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN JACKSON							2. Date of Death Month Day Year JAN. 30, 2007	3. Time of Death M 5:00 A M
	4a. Facility Name (If not institution, give street and number) Cherry Lane Nursing Home			4b. City, Town, or Location of Death Laurel			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 219-14-5000		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 09-24-1923		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent		10a. State Maryland 10b. County Prince George's 10c. City, Town or Location College Park			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 4811 Nantucket Road				10f. Zip Code 20740		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Secretary		16b. Kind of Business/Industry US Department of Agriculture				
	17. Father's Name (First, Middle, Last) Homer Burns				18. Mother's Name (First, Middle, Maiden Surname) Maude Moore				
	19a. Informant's Name/Relationship (Type, Print) Gary W. Jackson - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4811 Nantucket Road, College Park, Maryland 20740				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 02-01-2007	20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimers Dementia				Approximate Interval Between Onset and Death				
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition; Decubitus Ulcer on Hip				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	27. Manner of Death Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D43351				
	29b. Signature and title of certifier 				29d. Date signed (Month, Day, Year) January 30, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechi Frederick Okwara, MD 6201 Greenbelt Road, Suite U-15, College Park, MD				20740				
	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

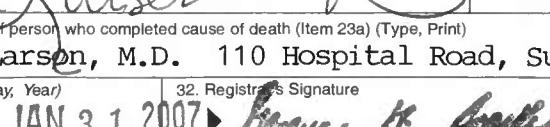
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04215

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Roche Johnson							2. Date of Death Month Day Year January 28 2007	3. Time of Death 3:50 P M	
	4a. Facility Name (If not institution, give street and number) 7999 Stream Walk Way			4b. City, Town, or Location of Death Chesapeake Beach			4c. County of Death Calvert			
Funeral Director	5. Social Security Number 046-03-2682		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov. 12 1914	9. Birthplace (State or Foreign Country) Connecticut		
	10a. State MD		10b. County Calvert		10c. City, Town or Location Chesapeake Beach			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 7999 Stream Walk Way				10f. Zip Code 20732			10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) James L. Roche					18. Mother's Name (First, Middle, Maiden Surname) Alice Bower					
19a. Informant's Name/Relationship (Type, Print) Alice Oliver, daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7999 Stream Walk Way, Chesapeake Beach, MD 20732					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 01-30-07	20c. Location - City or Town, State Alexandria, VA				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rausch Funeral Home, P.A. Owings, MD 20736								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
<p>a. Congestive Heart Failure Due to (or as a consequence of): Renal Failure</p> <p>b. Due to (or as a consequence of): Aortic Stenosis</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AFib COPD									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D51722			29d. Date signed (Month, Day, Year) January 29, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kimberly Larson, M.D. 110 Hospital Road, Suite 111, Prince Frederick, MD 20678		32. Registrar's Signature 								
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04216

For
State
Registrar

1-

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Gayle Alvesta Johnson		JAN. 21 2007				1605 M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Peninsula Regional Medical Center		Salisbury				Wicomico	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
244-04-6901		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	47 Yrs.			May 22, 1959	NC
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
MD	Somerset	Princess Anne					
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
12450 Independence Court			21853			USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
Elementary/Secondary (0-12)		College (1-4 or 5+)		Nursing Assistant			Various Families
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
Herbert Washington Bailey				Annis Johnson			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Linda Marie Johnson/sister		2711 Sater St., Durham, NC 27703					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
		Glenview Memorial Park		1/27/2007	Durham, NC		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. Due to (or as a consequence of): <i>Cardiac Arrest</i>							
b. Due to (or as a consequence of): <i>Complicated Cardiopulmonary</i>							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
Approximate Interval Between Onset and Death 20 min							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Enteric Escherichia coli Septicemia - Chronic Renal Failure - Diabetes Mellitus							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 							
29c. License number 0-20050 29d. Date signed (Month, Day, Year) 1/21/07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. S. Chan</i>							
31. Date filed (Month, Day, Year)		32. Registrar's Signature 					
JAN 30 2007							

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#5perINF2/8/07, BMW, MoCo
AMEND#20perFH1/31/07, BMW, MoCo

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04217

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) John William Krasauskas										2. Date of Death Month Day Year		3. Time of Death	
		4a. Facility Name (If not institution, give street and number) Bedford Court Assisted Living										4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 578-32-4477		6. Sex M		7. Age (In yrs. last birthday) 97		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Sept. 26, 1909		9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 Yes X No							
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) French Chef		16b. Kind of Business/Industry Federal Government											
17. Father's Name (First, Middle, Last) John Peter Krasauskas		18. Mother's Name (First, Middle, Maiden Surname) Alene Urnevicius													
19a. Informant's Name/Relationship (Type, Print) Jacqueline M. Kramer/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15321 Bitterroot Way, Rockville, MD 20853													
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		21. Signature of Funeral Service Licensee Andrew Cole		22. Name and Address of Facility Francis J. Collins Funeral Home Inc.		23. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.		24. Location - City or Town, State Silver Spring, Maryland		25. Approximate Interval Between Onset and Death 2 Months			
26. Physician /Medical Examiner		27. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Least		28. Date of Injury (Month, Day Year)		29. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi, M.D 3305 N. Leisure World Blvd, Silver Spring, MD 20906		31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature James A. Rossi		33. Date signed (Month, Day, Year) January 29, 2007	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		34. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown													
35. Was an autopsy performed? 1 Yes 2 No		36. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No													
37. Did case referred to medical examiner? 1 Yes 2 No		38. Place of Death (Check only one) Assisted Living Facility													
39. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		40. Date of Injury (Month, Day Year)		41. Time of Injury		42. Injury at Work? M		43. Describe how injury occurred		44. Location (Street and Number or Rural Route Number, City or Town, State)					
45. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
46. Signature and title of certifier James A. Rossi, M.D		47. License number D24543		48. Date signed (Month, Day, Year) January 29, 2007											
49. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi, M.D 3305 N. Leisure World Blvd, Silver Spring, MD 20906															
50. Date filed (Month, Day, Year) JAN 30 2007		51. Registrar's Signature James A. Rossi													
52. State Registrar															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

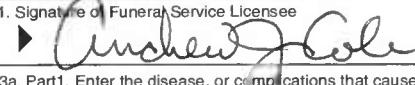
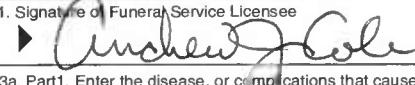
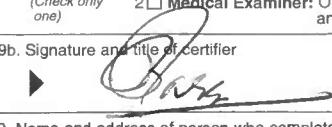
Reg. No.

2007 01 210

3. Time of Death

Month Day Year
January 27, 2007 10:30 a M

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Garland Elgeworth King						2. Date of Death Month Day Year January 27, 2007		3. Time of Death 10:30 a M	
		4a. Facility Name (If not institution, give street and number) Fairland Adventist Nursing & Rehab.			4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 231-12-0175		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) Feb. 11, 1917		9. Birthplace (State or Foreign Country) Virginia	
To Be Completed by Funeral Director		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location College Park				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 5004 Apache Street			10f. Zip Code 20740			10g. Citizen of What Country? USA			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White		
		15. Decedent's Education (Specify only highest grade completed) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automotive Mechanic		16b. Kind of Business/Industry Automobile					
		17. Father's Name (First, Middle, Last) Talmage King				18. Mother's Name (First, Middle, Maiden Surname) Clara Wilkins					
		19a. Informant's Name/Relationship (Type, Print) Sandra K. Fleming/ Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2902 Regina Drive, Silver Spring, MD 20906						
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date Jan. 31, 2007		20c. Location - City or Town, State Washington, DC			
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prostate Cancer						Approximate Interval Between Onset and Death 1 Year			
		a. Due to (or as a consequence of): Prostate Cancer									
		b. Due to (or as a consequence of): 									
		c. Due to (or as a consequence of): 									
		d. Due to (or as a consequence of): 									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Seizure Disorder						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
										28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one)		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier 		29c. License number D28656						29d. Date signed (Month, Day, Year) January 29, 2007	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 8609 Second Avenue, #404B, Silver Spring, MD 20910									
State Registrar		31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

B+1

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04219

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Reid Katan		January 29, 2007		2:00 P M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
1132 Lake Ridge Drive		Sunderland		Calvert County
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	8. Date of Birth (Month, Day, Year)
041-26-2911		72	If Under 1 Year Months Days Hours Min.	May 25, 1934
10a. State		10b. County		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MD		Calvert County		Sunderland
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
1132 Lake Ridge Drive		20689		U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Analyst		16b. Kind of Business/Industry Federal Government
17. Father's Name (First, Middle, Last) Clarence Leroy Katan		18. Mother's Name (First, Middle, Maiden Surname) Shirley A. Reid		
19a. Informant's Name/Relationship (Type, Print) Patricia M. Katan (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1132 Lake Ridge Drive, Sunderland, Maryland 20689		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		20c. Location - City or Town, State Clinton, Maryland
21. Signature of Funeral Service Licensee ► Michael W. Lee		22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736		
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): PANCREATIC CARCINOMA		Approximate Interval Between Onset and Death 3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE CHRONIC OBSTRUCTIVE PULMONARY DISEASE				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D042049		29d. Date signed (Month, Day, Year) January 30, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alain G. Champaloup M.D. 14314 Old Marlboro Pike. Upper Marlboro, MD 20772		32. Registrar's Signature Lorraine B. Spangler		
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 220

Reg. No.

1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Anita Jean King

2. Date of Death

Month

Day

Year

Jan 31, 2007

3. Time of Death

12:00 p.m.

Physician
/Medical
ExaminerFuneral
Director

Usual Residence of Decedent
10a. State 10b. County 10c. City, Town or Location
Maryland Washington Hagerstown

10d. Inside City Limits
1□ Yes 2□ No

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

4a. Facility Name (If not institution, give street and number)

12304 Huyett Lane

4b. City, Town, or Location of Death

Hagerstown

Washington

4c. County of Death

Washington

5. Social Security Number

212-50-9847

6. Sex

1□ M 2□ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month Day Year)

May 4, 1952

9. Birthplace (State or Foreign Country)

Maryland

10e. Street and Number

12304 Huyett Lane

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2□ Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1□ Yes 2□ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1□ Yes 2□ No
Specify:

14. Race - American Indian, Black, White, etc.

Specify:
white15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12) 10
College (1-4 or 5+) 1016a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Oil Lubricating Manufacturer

17. Father's Name (First, Middle, Last)

Raymond G. Henson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Alice Robison

19a. Informant's Name/Relationship (Type, Print)

John D. King - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Hag. Mennonite Fellowship Cem. Feb. 6, 2007 Hagerstown, Maryland

21. Signature of Funeral Service Licensee

John D. King

22. Name and Address of Facility

Osborne Funeral Home, P.A.

21795

425 S. Conococheague St. Williamsport, Maryland

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Hematologic uterine Cancer*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Uterine Cancer*
Due to (or as a consequence of):

1 yr

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1□ Yes 2□ No
9□ Unknown23c. If yes, outcome of pregnancy
1□ Live birth 2□ Fetal death 3□ Ectopic pregnancy
4□ Pregnant at time of death 5□ Other (Specify)
9□ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Deep Venous Thrombosis
Diabetes Mellitus
Hospital Obesity*

23e. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

25. Was case referred to medical examiner?
1□ Yes 2□ No

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1□ Natural 5□ Pending investigation
2□ Accident 6□ Could not be determined
3□ Suicide 4□ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alfredo A. Capizzi MD

29c. License number

D0062607

29d. Date signed (Month, Day, Year)

February, 01, 2007

31. Date filed (Month, Day, Year)

FEB 02 2007

32. Registrar's Signature

Alfredo A. Capizzi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04221

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM B. LATHAM							2. Date of Death Month Day Year JANUARY 26 2007 5:05AM	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) Doctor's Hospital				4b. City, Town, or Location of Death Lanham			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 405-32-4492	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-23-1928	9. Birthplace (State or Foreign Country) Kentucky			
To Be Completed by Funeral Director	10a. State Maryland				10b. County Prince George's			10c. City, Town or Location College Park		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 5012 Roanoke Place				10f. Zip Code 20740			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Metalurgist			16b. Kind of Business/Industry US Post Office		
	17. Father's Name (First, Middle, Last) Charles Latham				18. Mother's Name (First, Middle, Maiden Surname) Laura Lucille Perrine					
	19a. Informant's Name/Relationship (Type, Print) Shelly L. Hickerson - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6007 Jamestown Road, Hyattsville, Maryland 20782					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Shelly May		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			Date 2/2/2007	20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee Shelly May		22. Name and Address of Facility Gasch's Funeral Home, P.A.			4739 Baltimore Ave. Hyattsville, MD 20781				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Aspirate. Pneumonia								Approximate Interval Between Onset and Death 1 week	
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): Aspirate. Pneumonia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Pneumonia Malnutrition								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D45666			29d. Date signed (Month, Day, Year) 1/26/07				
	29b. Signature and title of certifier Shelly May		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300, CALLANT Box CM 12U Bocie MD 20711			31. Date filed (Month, Day, Year) JAN 31 2007			32. Registrar's Signature Barbara D. Smith	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 01 222

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leon Lambrechts							2. Date of Death Month Day Year January 30 2007	3. Time of Death 1:15 AM		
	4a. Facility Name (If not institution, give street and number) Ellicott City Health & Rehab. Ctr.			4b. City, Town, or Location of Death Ellicott City			4c. County of Death Howard				
Funeral Director	5. Social Security Number 503-14-8078	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 07-16-1921	9. Birthplace (State or Foreign Country) South Dakota				
Usual Residence of Decedent											
10a. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 10210 Sand Trap Court				10f. Zip Code 21042				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1942- If Yes, Give Year or Dates: 1946			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Electrical Technician			17. Father's Name (First, Middle, Last) Cline Bernard Lambrechts			
18. Mother's Name (First, Middle, Maiden Surname) Lilah Purintun		19a. Informant's Name/Relationship (Type, Print) Donald Bruce Lambrechts - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10210 Sand Trap Court, Ellicott City, MD 21042			20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Cedar Hill Cemetery		Date 02/02/2007	20c. Location - City or Town, State Suitland, Maryland	
21. Signature of Funeral Service		22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease		Approximate Interval Between Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (isease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of): Bacterial Pneumonia									
c. Due to (or as a consequence of): Senile Dementia		d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier S. Ramey								29c. License number D 30641	29d. Date signed (Month, Day, Year) January 30 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rameri Sabapathy 201-109 Back River Neck Road Baltimore Maryland 21212											
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Janice D. Smith									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State AVEND#23a-TperMD1/30/07 BM, MOCO
Registrant AVEND#23a-TperMD1/30/07, BM, MOCO

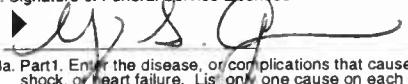
Certificate of Death

Reg. No. 2007 04223

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sophie B. Lyman				2. Date of Death Month January Day 19 , Year 2007	3. Time of Death 5:00 P M		
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 577-07-9765	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) July 7, 1911	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number # 4 Saddlerock Court		10f. Zip Code 20902	10g. Citizen of What Country? U. S. A.				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12)	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: College (1-4 or 5+)	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney	16b. Kind of Business/Industry Federal				
	17. Father's Name (First, Middle, Last) Meyer Bookoff			18. Mother's Name (First, Middle, Maiden Surname) Annie (Unknown)				
	19a. Informant's Name/Relationship (Type, Print) Brenda Sandler - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6216 Yorkshire Terrace, Bethesda, Maryland 20814					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King David Mem. Gdns	Date 1/21/2007	20c. Location - City or Town, State Falls Church, Virginia			
	21. Signature of Funeral Service Licensee Donald C. Stottlinger		22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. Severe Sepsis and Hypertension Due to (or as a consequence of):</p> <p>b. Acute Myocardial Infraction Due to (or as a consequence of):</p> <p>c. Respiratory Failure due to Pneumonia Due to (or as a consequence of):</p> <p>d. Acidosis</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Pneumonia						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number 6K9758876					29d. Date signed (Month, Day, Year) 1/20/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kapoor, Rama 1500 Forest Glen Road, Silver Spring, Maryland 20910							
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007	32. Registrar's Signature Barbara K. Jones						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 04224
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALEKSANDR LIKHTMAN				2. Date of Death Month JANUARY Day 26 , Year 2007	3. Time of Death 2:45 P.M.																																		
	4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery																																			
Funeral Director	5. Social Security Number 212-59-2773	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 31, 1927	9. Birthplace (State or Foreign Country) Russia																																	
	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville						10d. Inside City Limits 1 Yes 2 No																																	
To Be Completed by Funeral Director	10e. Street and Number 6121 Montrose Road			10f. Zip Code 20852		10g. Citizen of What Country? Russia																																		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Caucasian																																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Electrical Engineer			16b. Kind of Business/Industry Electrical																																		
	17. Father's Name (First, Middle, Last) Yefim Yakovlevich Likhtman			18. Mother's Name (First, Middle, Maiden Surname) Berta Gavrilovna Sapir																																				
	19a. Informant's Name/Relationship (Type, Print) Antonina Konstantinova / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7620 Male Avenue #301, Takoma Park, MD 20912																																				
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		Date 01/30/2007	20c. Location - City or Town, State Brentwood, Maryland																																		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852																																					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																							
	<table border="0"> <tr> <td>a. BILATERAL PNEUMONIA Due to (or as a consequence of):</td> <td colspan="7"></td> </tr> <tr> <td>b. PARKINSON DISEASE Due to (or as a consequence of):</td> <td colspan="7"></td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td colspan="7"></td> </tr> <tr> <td>d. _____</td> <td colspan="7"></td> </tr> </table>								a. BILATERAL PNEUMONIA Due to (or as a consequence of):								b. PARKINSON DISEASE Due to (or as a consequence of):								c. _____ Due to (or as a consequence of):								d. _____							
a. BILATERAL PNEUMONIA Due to (or as a consequence of):																																								
b. PARKINSON DISEASE Due to (or as a consequence of):																																								
c. _____ Due to (or as a consequence of):																																								
d. _____																																								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			23d. Date of delivery Month Day Year																																		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																							
	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown																																							
	24a. Was an autopsy performed? 1 Yes 2 No																																							
	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No																																							
	25. Was case referred to medical examiner? 1 Yes 2 No																																							
	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)																																							
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide																																							
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M																																							
	28c. Injury at Work? 1 Yes 2 No																																							
	28d. Describe how injury occurred																																							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																																							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)																																							
	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																							
	29b. Signature and title of certifier  BARBARA KAZIMY, M.D.																																							
	29c. License number D 35436																																							
	29d. Date signed (Month, Day, Year) JANUARY 26, 2007																																							
	30. Name and address of person who completed cause of death (from 23a) (Type, Print) BARBARA KAZIMY, 6121 MONTROSE ROAD, ROCKVILLE, MD 20852																																							
	31. Date filed (Month, Day, Year) JAN 30 2007																																							
	32. Registrar's Signature 																																							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04225

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Lillian Elaine Lowe						2. Date of Death Month Day Year January 26, 2007	3. Time of Death 2:42 A M	
Funeral Director		4a. Facility Name (If not institution, give street and number) 6130 8th Street			4b. City, Town, or Location of Death Chesapeake Beach			4c. County of Death Calvert		
To Be Completed by Funeral Director		5. Social Security Number 578-54-5244		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov 4, 1941		9. Birthplace (State or Foreign Country) N. Carolina	
		Usual Residence of Decedent		10a. State MD		10b. County Calvert	10c. City, Town or Location Chesapeake Beach			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number 6130 8th Street					10f. Zip Code 20732	10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Switch Board Operator			16c. Kind of Business/Industry Medical Office
		17. Father's Name (First, Middle, Last) Burris		Holden			18. Mother's Name (First, Middle, Maiden Surname) Bertha Mae Radford			
		19a. Informant's Name/Relationship (Type, Print) Robert A. Lowe, Sr. (husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6130 8th Street Chesapeake Beach, MD 20732						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National			Date Jan 31	20c. Location - City or Town, State Suitland, MD		
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Glioblastoma multiforme 06 Frontal lobe of Brain			Approximate Interval Between Onset and Death 3 weeks					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive Air way disease					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of Injury : At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D 50653			29d. Date signed (Month, Day, Year) 1-26-2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851- Deale churchton Road. Deale MD 20751		32. Registrar's Signature 								
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at

To the Hospital or Attended
within 24 hours after death.

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar		1. Decedent's Name (First, Middle, Last) MARGARET S LEATHERMAN				2. Date of Death Month January Day 25 , Year 2007		3. Time of Death 3:10 A M			
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick			
Funeral Director		5. Social Security Number 220-05-4755		6. Sex 1 □ M 2 X F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) Sept. 20, 1919	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland 10b. County Frederick				10c. City, Town or Location Frederick					
		10e. Street and Number 615 Biggs Avenue				10f. Zip Code 21702		10g. Citizen of What Country? United States			
		11. Marital Status 1 □ Never Married 2 X Married		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Lab Assistant		16b. Kind of Business/Industry Healthcare					
		17. Father's Name (First, Middle, Last) John H. Stewart				18. Mother's Name (First, Middle, Maiden Surname) Lucy Topper					
		19a. Informant's Name/Relationship (Type. Print) Gail Smith / Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4612 Old National Pike, Middletown, MD 21769							
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date 1-27-2007	20c. Location - City or Town, State Frederick, Maryland				
		21. Signature of Funeral Service Licensee <i>Kourtney Staffer</i>		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702							
		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death 3 - 4 days	
		Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of): <i>Pneumonia</i>							
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):							
				c. Due to (or as a consequence of):							
				d. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Hypertension								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown	
		25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
		27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) 2 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier <i>Hirsh R. Schmid</i>		29c. License number D51643		29d. Date signed (Month, Day, Year) 1/25/07					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 C Thomas Thompson Jr		31. Date filed (Month, Day, Year) JAN 30 2007						32. Registrar's Signature <i>Janice B. Spotts</i>	

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 227

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) MARTHA SUE LANE						2. Date of Death Month Day Year Feb. 1 2007		3. Time of Death 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL						4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON						
Funeral Director		5. Social Security Number 417-28-8329		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 15, 1922		9. Birthplace (State or Foreign Country) ALABAMA						
To Be Completed by Funeral Director		10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location BOONSBORO										
		10e. Street and Number 42 SOUTH MAIN STREET		10f. Zip Code 21713		10g. Citizen of What Country? U.S.A.										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) COLLEGE		16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME								
17. Father's Name (First, Middle, Last) WILLIAM HYDE WILSON		18. Mother's Name (First, Middle, Maiden Surname) ESTELLE HOUGHSON														
19a. Informant's Name/Relationship (Type, Print) DAVID W. LANE/SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 780 SHANGHAI ROAD, BERKELEY SPRINGS, WV 25411														
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► Paul M. Dean		20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY		Date 2/05/2007		20c. Location - City or Town, State BOONSBORO, MARYLAND										
21. Signature of Funeral Service Licensee Paul M. Dean		22. Name and Address of Facility BAST FUNERAL HOME		7606 Old National Pike Boonsboro, Maryland 21713												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death					
a. Cardio pulmonary Arrest Due to (or as a consequence of):																
b. Respiratory failure Due to (or as a consequence of):																
c. Pneumonia Due to (or as a consequence of):																
d. _____																
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check one Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29b. Signature and title of certifier Dr. W. Lane		29c. License number D 58267		29d. Date signed (Month, Day, Year) 2-1-07												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. W. Lane 1110 Medical Campus Rd Htg. Md 21740																
31. Date filed (Month, Day, Year) FEB 02 2007		32. Registrar's Signature James B. Sparks														

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 22

1- For State
RegistrarPhysician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 0035 hrs	
MICHAEL WAYNE MURRAY		January 20, 2007					
4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's	
5. Social Security Number 577-96-8585		6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) 12/14/1964	9. Birthplace (State or Foreign Country) DC
Usual Residence of Decedent 10a. State DC 10b. County 10c. City, Town or Location Washington							
10e. Street and Number 907 9th St. N.E.			10f. Zip Code 20002			10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs.			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Technician			16b. Kind of Business/Industry Unknown	
17. Father's Name (First, Middle, Last) Herod Murray, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Barbara Wilson			
19a. Informant's Name/Relationship (Type, Print) Sean Holloway/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Valley Ave. S.E. Washington, D.C. 20032				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Ft. Lincoln		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln		Date 2-2-2007	20c. Location - City or Town, State Brentwood, Md.		
21. Signature of Funeral Service Licensee J. P. Marshall		22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th st. N.W. Washington, DC 20011					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracranial Hemorrhage Due to (or as a consequence of): b. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated							
29b. Signature and title of certifier Tasha Greenberg MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 20, 2007	
30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature [Signature]					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 229

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANTHONY PAUL MORENCY						2. Date of Death Month Day Year January 29, 2007	3. Time of Death 8:05 p M	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 253-68-0076	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-26-1942	9. Birthplace (State or Foreign Country) Maine		
	Usual Residence of Decedent 10a. State Maryland						10d. Inside City Limits 1 X Yes 2 □ No		
10b. County Prince George's						10c. City, Town or Location Hyattsville			
10e. Street and Number 3205 Kimberly Road				10f. Zip Code 20782		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1960- If Yes, Give Year or Dates: 1963			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Accountant - Auditor			16b. Kind of Business/Industry Federal Government		
17. Father's Name (First, Middle, Last) Joseph Ernest Morency				18. Mother's Name (First, Middle, Maiden Surname) Marie Virginia Lebrasseur					
19a. Informant's Name/Relationship (Type, Print) Frank F. Leonard - Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Kimberly Road, Hyattsville, MD 20782					
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 02/02/2007	20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee Karen T. May				22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. Sepsis Due to (or is a consequence of): liver cirrhosis alcholic</p> <p>b. Due to (or as a consequence of): hepatitis encephalopathy</p> <p>c. Due to (or is a consequence of): coronary artery disease</p>									
Approximate Interval Between Onset and Death									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown									
24a. Was an autopsy performed? 1 □ Yes 2 X No									
24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No									
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day, Year) 1 X January 30, 2007		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home									
28f. Location (Street and Number or Rural Route Number, City or Town, State) Hyattsville, MD									
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Steven Tee				29c. License number D46998			29d. Date signed (Month, Day, Year) January 30, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Tee, MD 3415 Hamilton ST #1 Hyattsville, MD									
31. Date filed (Month, Day, Year) JAN 31 2007				32. Registrar's Signature Barbara A. Sparks					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 230

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death		
	GABRIEL ISATAH MATA-DAVIS						Month Day Year JANUARY 27 2007		Year 2 : 45 AM		
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
	NATIONAL INSTITUTES OF HEALTH			BETHESDA			MONTGOMERY				
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
	600-73-6116		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	9 Yrs.	Months	Days	Hours	Min.	Aug. 19, 1997	Arizona	
Usual Residence of Decedent											
AZ	10a. State		10b. County		10c. City, Town or Location					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
					Phoenix						
	10e. Street and Number					10f. Zip Code			10g. Citizen of What Country?		
	6421 W. Hughes Dr.					85043			USA		
	11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
	1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White		
	3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry					
	Elementary/Secondary (0-12) unk			College (1-4 or 5+)		None			None		
	17. Father's Name (First, Middle, Last) Richard Davis					18. Mother's Name (First, Middle, Maiden Surname) Lori Mata					
	19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	Lori Mata/Mother				6421 W. Hughes Dr. Phoenix, AZ. 85043						
	20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
	1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State			Holy Cross Cemetery			2-3-2007		Phoenix, AZ.		
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
	21. Signature of Funeral Service Licensee ► J. P. Marshall			22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition resulting in death)										
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
	<p>a. Bleeding secondary to thrombocytopenia Due to (or as a consequence of): myobacterium avium complex infection, portal hypertension</p> <p>b. Due to (or as a consequence of): liver failure</p> <p>c. Due to (or as a consequence of): Immunodeficiency due to NFkB essential modulator defect</p> <p>d. Due to (or as a consequence of): since birth</p>										
	Approximate Interval Between Onset and Death 1 day 5 years 5 years since birth										
	IF FEMALE:			23c. If yes, outcome pf pregnancy						23d. Date of delivery	
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
	Gastrointestinal hemorrhage Disseminated intravascular coagulation										
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one)							
				Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D0059363							
				29d. Date signed (Month, Day, Year) 1/28/2007							
	29b. Signature and title of certifier GULBU UZEL, MD			29c. License number D0059363							
				29d. Date signed (Month, Day, Year) 1/28/2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			31. Date filed (Month, Day, Year) JAN 30 2007							
	GULBU UZEL, MD 334141			32. Registrar's Signature James B. Apelt							

Baltimore, Maryland 21215-0036
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

State Registrar

#2/15/17 needs to be amended per Non

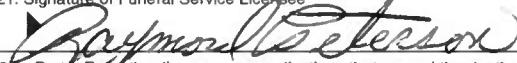
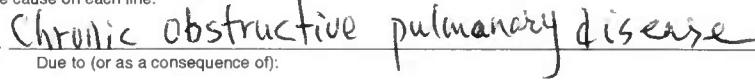
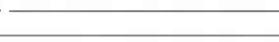
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 23

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES EDWARD MERCER				2. Date of Death Month Day Year January 28, 2007	3. Time of Death 9:25 P M		
	4a. Facility Name (If not institution, give street and number) 709 East South St.		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick			
Funeral Director	5. Social Security Number 220-26-0620	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 2, 1929	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 709 East South St.		10f. Zip Code 21701		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-52	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Small Engine Mechanic	16b. Kind of Business/Industry Mechanical repair				
	17. Father's Name (First, Middle, Last) Frank John Mercer			18. Mother's Name (First, Middle, Maiden Surname) Emma Elizabeth Staub				
	19a. Informant's Name/Relationship (Type, Print) Mary Mercer / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 E. South St. / Frederick, Maryland 21701					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cem.	Date FEB. 1, 2007	20c. Location - City or Town, State Frederick, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____ Approximate Interval Between Onset and Death							
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number MES1831, FL		29d. Date signed (Month, Day, Year) Jan. 29, 2007			
Medical Certification: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jianming Xie, 510 Butler Ave., Martinsburg, WV 25405							
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

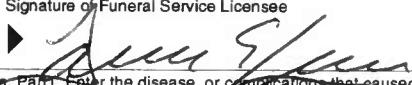
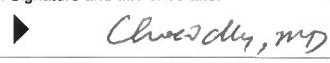
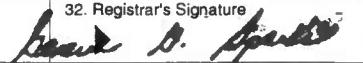
State of Maryland / Department of Health and Mental Hygiene

Amend #5, per FH, g866, 4/5/07 TT

Certificate of Death

Reg. No.

2007 04232

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death	
	Frederick K. Maples							1 27 07	12:50a	
Funeral Director	4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death	4c. County of Death	
	Bethesda Health and Rehab.							Bethesda	Montgomery	
5. Social Security Number 579-36-1929		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month Day Year) 10/31/1929	9. Birthplace (State or Foreign Country) Washington, DC	
Usual Residence of Decedent		10a. State MD		10b. County Montgomery		10c. City, Town or Location Bethesda			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3 Pooks Hill Road				10f. Zip Code 20814			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Af. American		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4			16b. Kind of Business/Industry Office Manager			16c. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Frederick Martin Maples					18. Mother's Name (First, Middle, Maiden Surname) Ella Maples Johnson					
19a. Informant's Name/Relationship (Type, Print) Ann Maples-Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Pooks Hill Rd., Bethesda, MD 20814					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cm.			Date	20c. Location - City or Town, State 1/31/07 Brentwood, MD				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Atherosclerotic cardiovascular disease						Approximate Interval Between Onset and Death UNKNOWN		
		Due to (or as a consequence of):								
		b.			Due to (or as a consequence of):					
		c.			Due to (or as a consequence of):					
		d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
<i>Dementia and Cerebral atrophy, Hypertension, Congestive heart failure, Renal failure, Benign prostatic hypertrophy</i>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D43121			29d. Date signed (Month, Day, Year) 1/27/07					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NURUL CHOWDHURY, MD; 15216 DINO DRIVE; BURTONSVILLE, MD 20866										
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04233

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRY RAY MACKLEY						2. Date of Death Month Day Year JANUARY 28, 2007	3. Time of Death 1:45A M	
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL			4b. City, Town, or Location of Death FREDERICK			4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 187-16-6282	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 1, 1923	9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	10a. State Maryland			10b. County Frederick			10c. City, Town or Location Frederick		
	10e. Street and Number 604 Mary St.			10f. Zip Code 21701			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commercial Representative			16b. Kind of Business/Industry Electric Company		
	17. Father's Name (First, Middle, Last) Morris A. Mackley				18. Mother's Name (First, Middle, Maiden Surname) Eva Pearl Weagley				
	19a. Informant's Name/Relationship (Type, Print) Marilyn Mackley / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Mary St. / Frederick, MD. 21701					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Stauffer Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date JAN. 30, 2007	20c. Location - City or Town, State Frederick, MD		
	21. Signature of Funeral Service Licensee <i>Marilyn Mackley Stauffer</i>			22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line.) Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	<p>a. FAILURE TO THRIVE Due to (or as a consequence of): INTRACRANIAL HEMORRHAGE</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>SIBTE A KAZMI, MD</i>					
				29c. License number D 47951			29d. Date signed (Month, Day, Year) 01-29-2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBTE A KAZMI, MD 814 Toll House Ave. FREDERICK, MD 21701								
	31. Date filed (Month, Day, Year) JAN 30 2007			32. Registrar's Signature <i>Sanne B. Spaulding</i>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 23

For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

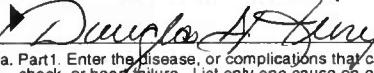
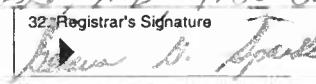
Baltimore, Maryland 21215-0036

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1- Physician /Medical Examiner		Decedent's Name (First, Middle, Last) Patrick Dennis Messina						2. Date of Death Month Day Year Jan 31 2007		3. Time of Death 9:05AM M							
		4a. Facility Name (If not institution, give street and number) 10938 Garrison Hollow Road						4b. City, Town, or Location of Death Clear Spring		4c. County of Death Washington County							
Funeral Director		5. Social Security Number 181-34-1363	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63	If Under 1 Year Months Yrs.	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) March 13 1943	9. Birthplace (State or Foreign Country) Pennsylvania									
		Usual Residence of Decedent 10a. State Maryland						10b. County Washington		10c. City, Town or Location Clear Spring							
		10e. Street and Number 10938 Garrison Hollow Road						10f. Zip Code 21722		10g. Citizen of What Country? U.S.A.							
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White						
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+			16b. Kind of Business/Industry Teacher			17. Father's Name (First, Middle, Last) Patrick Messina						
		19a. Informant's Name/Relationship (Type, Print) Donna J. Messina (wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10938 Garrison Hollow Road Clear Spring Maryland 21722			18. Mother's Name (First, Middle, Maiden Surname) Geraldine Collett Messina									
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory			Date 2-4-2007	20c. Location - City or Town, State Smithsburg Maryland								
		21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Donald Edwin Thompson F.H. Inc. 13607 National Pike Clear Spring, Maryland 21722									
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last						Approximate Interval Between Onset and Death 6 months									
		<p>a. Brain metastasis Due to (or as a consequence of):</p> <p>b. Colon cell carcinoma Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>															
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
														24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number 246473						29d. Date signed (Month, Day, Year) JAN 31 2007			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugh Hanrahan MD 1130 OPOC CT. Hagerstown, MD 21740															
		31. Date filed (Month, Day, Year) FEB 01 2007						32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04235

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Virginia E. Martin</i>					2. Date of Death Month <input checked="" type="checkbox"/> 1 Day <input checked="" type="checkbox"/> 30 Year <input checked="" type="checkbox"/> 07	3. Time of Death <i>0715 AM</i>
	4a. Facility Name (If not institution, give street and number) <i>Coastal Hospice At The Lake</i>		4b. City, Town, or Location of Death <i>Salisbury</i>			4c. County of Death <i>Wicomico</i>	
Funeral Director	5. Social Security Number <i>552-32-7733</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>05 21 1915</i>	9. Birthplace (State or Foreign Country) <i>N.C.</i>
	10a. State <i>MD</i>		10b. County <i>Worcester</i>		10c. City, Town or Location <i>Berlin</i>		
To Be Completed by Funeral Director	10e. Street and Number <i>9333 Pitts RD</i>			10f. Zip Code <i>21811</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>No</i>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 11</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>			16b. Kind of Business/Industry <i>Own Home</i>
	17. Father's Name (First, Middle, Last) <i>Clinton Creasy</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Bessie Bray</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Betty Jane Holland</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9333 Pitts RD, Berlin, MD 21811</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Evergreen Cemetery</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Evergreen Cemetery</i>		Date <i>02/02/2007</i>	20c. Location - City or Town, State <i>Berlin, MD</i>	
21. Signature of Funeral Service Licensee <i>Jacqueline J. Bafferty</i>			22. Name and Address of Facility <i>The Burbage Funeral Home</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): <i>Perforated Abdominal Viscera</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <i>1/30/07</i>		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>David E. Conall, MD</i>		29c. License number <i>D26278</i>			29d. Date signed (Month, Day, Year) <i>1-30-07</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David E. Conall, MD Coastal Hospice PO Box 1733 Salisbury, MD 21802</i>							
31. Date filed (Month, Day, Year) <i>JAN 31 2007</i>		32. Registrar's Signature <i>Glenn B. Speare</i>					

Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BA 4
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registra Amend #16b, 1-30-07, per FHDC HCD, a1 Certificate of Death

Reg. No. 2007 04236

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris LaRue Mitchell							2. Date of Death Month Day Year January 29, 2007	3. Time of Death 6:00 A M
	4a. Facility Name (If not institution, give street and number) Mariner Health of Overlea			4b. City, Town, or Location of Death Baltimore			4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 218-09-9219	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Aug 4, 1920	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State MD			10b. County Baltimore City			10c. City, Town or Location Baltimore City		
To Be Completed by Funeral Director	10e. Street and Number 6116 Belair Road			10f. Zip Code 21206			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify:		
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson			16b. Kind of Business/Industry Retail Sales Real Estate		
	17. Father's Name (First, Middle, Last) George R. Gerwig			18. Mother's Name (First, Middle, Maiden Surname) Augusta L. Semone					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Arthur Fischer/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Budds Landing Rd. Warwick, MD 21912					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Beverly L. Heckrotte			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			Date 01/30/07	20c. Location - City or Town, State Beltsville, MD	
	21. Signature of Funeral Service Licensee Beverly L. Heckrotte			22. Name and Address of Facility Goin Home Cremation Service P.O. Box 784 M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovascular accident			23b. Approximate Interval Between Onset and Death 2 months					
	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Artrial fibrillation								
	23d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home									
28f. Location (Street and Number or Rural Route Number, City or Town, State) TOWSON MD 21204									
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Doris LaRue Mitchell									
29c. License number MD 04236									
29d. Date signed (Month, Day, Year) JANUARY 29 2007									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIS AUSTIN MD 21205 OXFORD VALLEY TOWNSHIP MD 21204									
31. Date filed (Month, Day, Year) JAN 30 2007									
32. Registrar's Signature Debra B. Goss									

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.																
State of Maryland / Department of Health and Mental Hygiene																
Certificate of Death																
Reg. No. 2007 04237																
1- For State Registrar		1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death					
		Elizabeth Messick							Month 01		Day 27		Year 2007			
		4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death		4c. County of Death					
		Coastal Hospice at the Lake							Salisbury		Wicomico					
Physician /Medical Examiner		5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)			If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
		217-28-3007		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		74 Yrs.			Months 1		Days 0		Hours 0		Min. 0	
Funeral Director		10a. State		10b. County		10c. City, Town or Location									10d. Inside City Limits	
		MD		Wicomico		Salisbury									<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director		10e. Street and Number					10f. Zip Code			10g. Citizen of What Country?						
		126 Lakeview Drive					21804			USA						
Physician /Medical Examiner		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.						
		<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: White						
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry									
		Elementary/Secondary (0-12) 12		College (1-4 or 5+) Caretaker			Medical									
Physician /Medical Examiner		17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)									
		Edward Lee Adkins					Edith Adkins									
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
		Sammuel Messick - husband		126 Lakeview Drive, Salisbury, MD 21804												
Physician /Medical Examiner		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State							
		<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Crematory of Delmarva			1-29-07		Delmar, Delaware							
Medical Certification: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee		22. Name and Address of Facility			Bounds Funeral Home									
		Denee S Kelly		705 E. Main Street, Salisbury, MD 21804												
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
		Approximate Interval Between Onset and Death														
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)														
		MALIGNANT NEOPLASM OF THYROID GLAND														
Physician /Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
		MALIGNANT LYMPHOMA CANCER														
Physician /Medical Examiner		IF FEMALE:		23c. If yes, outcome pf pregnancy			23d. Date of delivery									
		23b. Was decedent pregnant in the past 12 months?		<input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			<input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)			Month		Day		Year		
Physician /Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
		23e. Did tobacco use contribute to the cause of death?														
Physician /Medical Examiner		<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown														
		24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?												
Physician /Medical Examiner		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No												
Physician /Medical Examiner		25. Was case referred to medical examiner?		26. Place of Death Check only one												
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
Physician /Medical Examiner		27. Manner of Death		28a. Date of Injury (Month, Day Year)			28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred					
		<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					M		<input type="checkbox"/> Yes <input type="checkbox"/> No							
Physician /Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)											28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one)		29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)						
Physician /Medical Examiner		<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			T14256			1/27/07						
Physician /Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)			32. Registrar's Signature									
		Deers Head Hospice at the Lake Salisbury, MD 21804		JAN 29 2007			Rebecca M. Baack									

Within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 04 238

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dieu Hoang Nguyen				2. Date of Death Month Day Year January 26, 2007	3. Time of Death 9:10 p m			
	4a. Facility Name (If not institution, give street and number) 12705 Laurie Drive		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 577-66-5013	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. 	8. Date of Birth (Month, Day, Year) Oct. 5, 1945	9. Birthplace (State or Foreign Country) Vietnam		
	Usual Residence of Decedent 10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 Yes 2 No 		
To Be Completed by Funeral Director	10e. Street and Number 12705 Laurie Drive			10f. Zip Code 20904		10g. Citizen of What Country? USA			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 	14. Race - American Indian, Black, White, etc. Specify Asian					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4	16b. Kind of Business/Industry Accountant	Financial Management					
	17. Father's Name (First, Middle, Last) Tuong Van Nguyen			18. Mother's Name (First, Middle, Maiden Surname) Phi Phi Thi Tran					
	19a. Informant's Name/Relationship (Type. Print) Vu P. Nguyen/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 N. Matlack Street, #3F, West Chester, PA 19380					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Feb. 3, 2007	20c. Location - City or Town, State Silver Spring, Maryland		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Anshen J. Cole			22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 			Approximate Interval Between Onset and Death 					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 								
	a. <u>Hypertensive Cardiovascular Disease</u> Due to (or as a consequence of): 								
	b. <u>Diabetes Mellitus Type II</u> Due to (or as a consequence of): 								
	c. <u>Hypertension</u> Due to (or as a consequence of): 								
	d. <u>Hyperlipidemia</u> 								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 		23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 			23d. Date of delivery Month Day Year 			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 			
	25. Was case referred to medical examiner? 1 Yes 2 No 		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 			24a. Was an autopsy performed? 1 Yes 2 No 			
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 		28a. Date of Injury (Month, Day Year) 	28b. Time of Injury M 	28c. Injury at Work? 1 Yes 2 No 	28d. Describe how injury occurred 			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 		28f. Location (Street and Number or Rural Route Number, City or Town, State) 						
	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner 		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 						
	29b. Signature and title of certifier Sean S Saed, MD		29c. License number D 60359			29d. Date signed (Month, Day, Year) 1/29/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sean S Saed, MD : 1120 New Hampshire Ave, Suite #305, Silver Spring, MD								
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 			2007 04 238			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04239

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ruth Nutter</i>							2. Date of Death Month 01 Day 28 Year 2007	3. Time of Death 11:25P.M.
	4a. Facility Name (If not institution, give street and number) <i>Deer's Head Hospital Center</i>			4b. City, Town, or Location of Death <i>Salisbury</i>			4c. County of Death <i>Wicomico</i>		
Funeral Director	5. Social Security Number <i>218-14-4226</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs Hours	8. Date of Birth (Month, Day, Year) <i>Oct. 13, 1920</i>	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>		
Usual Residence of Decedent									
10a. State <i>MD</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Delmar</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>8552 Engle Drive</i>				10f. Zip Code <i>21875</i>			10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>white</i>			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Home</i>		
17. Father's Name (First, Middle, Last) <i>Ralph Arbogast</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Edith Walker</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Linda J. Lloyd (daughter)</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8552 Engle Drive Delmar, MD 21875</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Crematory of Delmarva</i>					20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Crematory of Delmarva</i>		Date <i>1-30-2007</i>	20c. Location - City or Town, State <i>Delmar, Delaware</i>	
21. Signature of Funeral Service Licensee <i>H. G. Walker</i>					22. Name and Address of Facility <i>Short Funeral Home 13 E. Grove Street Delmar, DE 19940</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Systemic Inflammatory Response Syndrome</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Acute renal failure</i> <i>Dehydration</i> <i>Malnutrition</i>									
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
29b. Signature and title of certifier <i>Cee g</i>		29c. License number <i>D0063368</i>				29d. Date signed (Month, Day, Year) <i>1/29/07</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dong Hyun Lee, M.D. 351 Deer's Head Hospital Rd. Salisbury, MD 21802-2018</i>									
31. Date filed (Month, Day, Year) <i>JAN 30 2007</i>					32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner
For
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04240

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE A O'BRIEN				2. Date of Death Month Day Year 01 27 07	3. Time of Death 0941 M
Funeral Director	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
To Be Completed by Funeral Director	5. Social Security Number 577-28-9487	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/15/1921	If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/15/1921	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent Maryland Anne Arundel				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10a. State Maryland			10b. County Annapolis	10c. City, Town or Location Annapolis	
	10e. Street and Number 1958 Marconi Circle			10f. Zip Code 21401		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Analyst		16b. Kind of Business/Industry Federal Government	
	17. Father's Name (First, Middle, Last) John O'Brien				18. Mother's Name (First, Middle, Maiden Surname) Jane Dalton	
	19a. Informant's Name/Relationship (Type, Print) Jean M. O'Brien/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1958 Marconi Circle, Annapolis, Maryland 21401		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date 02/01/2007	20c. Location - City or Town, State Crownsville, Maryland
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration pneumonia Approximate Interval Between Onset and Death 5 D					
	23b. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 23c. Due to (or as a consequence of): End Stage Parkinsonism Approximate Interval Between Onset and Death 10 year					
	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					
	28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred					
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 					
	29c. License number D 21438					
	29d. Date signed (Month, Day, Year) January 27, 2007					
State Registrar	31. Date filed (Month, Day, Year) JAN 29 2007		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

**Physician/
Medical Examiner**

**Funeral
Director**

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Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 21

Date of Death

Month

Day

Year

Time of Death

1915 hrs

1- For State
Registrar

1. Decedent's Name (First, Middle, Last) Cory Eugene Pierce				2. Date of Death Month Day Year January 25, 2007		3 Time of Death 1915 hrs
4a. Facility Name (if not institution, give street and number) 1770 Tucker Road			4b. City, Town, or Location of Death Ft. Washington			4c. County of Death Prince George's
5. Social Security Number 213-39-4119	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 13 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs Hours Min.	8. Date of Birth (MM/DD/YYYY) May 16, 1993	9. Birthplace (State or Foreign Country) Washington, D.C.
10a. State Maryland			10b. County Prince Georges			10c. City, Town or Location Bowie
10e. Street and Number 12325 Chalford Lane			10f. Zip Code 20715			10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			14. Race - American Indian, Black, White, etc. Black
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:					
15. Decedent's Education (Specify only highest grade completed) 8th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Junior High School Student			16b. Kind of Business/Industry Saint Columba Catholic School
17. Father's Name (First, Middle, Last) Charles William Pierce				18. Mother's Name (First, Middle, Maiden Surname) Doreen Catherine Knight		
19a. Informant's Name/Relationship (Type, Print) Doreen Catherine Knight (Mother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12325 Chalford Lane; Bowie, Maryland 20715			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery			Date Feb. 2, 2007	20c. Location - City or Town, State Adelphi, Maryland	
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>[Signature]</i>				22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011		
21a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death) a. Head and Extremity Injuries Due to (or as a consequence of):						
b. _____ Due to (or as a consequence of):						
c. _____ Due to (or as a consequence of):						
d. _____						
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Jan 29, 2007		28b. Time of Injury 1857 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Passenger auto auto collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway						
28f. Location (Street and Number or Rural Route Number, City or Town, State) 1770 Tucker Road, Ft. Washington, Md.						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>[Signature]</i>			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) January 26, 2007
30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201						
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 24

4:50 p M

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

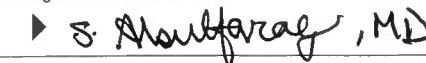
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

1 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death
③ To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death					
Ida Belle Pole		January 24, 2007				4:50 p M					
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death					
Shady Grove Adventist Hospital		Rockville				Montgomery					
5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 03, 1920	9. Birthplace (State or Foreign Country) North Carolina				
180-26-7989			86 Yrs.								
Usual Residence of Decedent											
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Maryland	Montgomery	Rockville									
10e. Street and Number	10f. Zip Code				10g. Citizen of What Country?						
1442 Traville Gardens Circle #411C		20850				United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Caucasian					
Elementary/Secondary (0-12) 12	College (1-4 or 5+) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Operator				16b. Kind of Business/Industry NIH					
17. Father's Name (First, Middle, Last) John Frank Beck				18. Mother's Name (First, Middle, Maiden Surname) Emma Gregg Rowell							
19a. Informant's Name/Relationship (Type, Print) Thomas Pole / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Anderson Avenue, Rockville, Maryland 20850								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory				Date 01/29/2007	20c. Location - City or Town, State Brentwood, Maryland					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Simple Tribute Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Due to (or as a consequence of): Acute Renal Failure b. Due to (or as a consequence of): Dehydration c. Due to (or as a consequence of): Dementia d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death days days mos-			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D31391				29d. Date signed (Month, Day, Year) January 25 2007					
29b. Signature and title of certifier 											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair Abulfarag, M.D. 15215 Shady Grove Road, Rockville, Maryland 20850											
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 21 3

Time of Death

14 54 PM

For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Floyd

Cecil

Pierce Jr.

2. Date of Death

Month

Day

Year

January

30

2007

Time of Death

14 54 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

MARYLAND

5. Social Security Number

219-74-6920

6. Sex

M

F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAY 25, 1962

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

MARYLAND

WASHINGTON

HAGERSTOWN

10d. Inside City Limits

Yes No

10e. Street and Number

11308 DOGWOOD DRIVE

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) MAINTENANCE MECHANIC

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

DEPT. OF ENERGY

17. Father's Name (First, Middle, Last)

FLOYD CECIL PIERCE SR.

18. Mother's Name (First, Middle, Maiden Surname)

HAZEL ALMEDA RENNER

19a. Informant's Name/Relationship (Type, Print)

JUNE M. PIERCE/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11308 DOGWOOD DRIVE, HAGERSTOWN, MARYLAND 21740

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

CEDAR LAWN MEM. PARK 2/03/2007

HAGERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonitis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital: Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marielle Byerly, Medical Doctor Res-000

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marielle Byerly, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 02 2007

Jean A. Franks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8H-10
State
Registrar

VOID

CERTIFICATE #

2007 - 04244

SEE

CERTIFICATE #

2006 - 43472

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 04245

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

5/28/07

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death			
Mary Helen Popiolek		Jan. 28, 2007				4:55 P M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
Salisbury Rehab + Nursing Ctr		Salisbury				Wicomico			
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/6/1915	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent		10a. State Maryland 10b. County Wicomico 10c. City, Town or Location Hebron				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 26702 Bevin Lane		10f. Zip Code 21830				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) - Housekeeper		16b. Kind of Business/Industry Domestic					
17. Father's Name (First, Middle, Last) Milton Dorsey				18. Mother's Name (First, Middle, Maiden Surname) Margaret Bransby					
19a. Informant's Name/Relationship (Type, Print) Peggy Shade/granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26702 Bevin Lane, Hebron, MD 21830					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 1/30/07	20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee ► Milton Dorsey CFSP				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death years					
a. <i>Coronary Artery Disease</i> Due to (or as a consequence of): <i>Constrictive Pericarditis</i> Due to (or as a consequence of):									
b. Due to (or as a consequence of): <i>Constrictive Pericarditis</i> Due to (or as a consequence of):				years					
c. Due to (or as a consequence of): d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 228349				29d. Date signed (Month, Day, Year) 1/29/07			
29b. Signature and title of certifier ► William H. Robins, M.D.		32. Registrar's Signature Helen A. Robins							
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, M.D. 200 Civic Ave. Salisbury, MD 21804									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04246

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Walter m. Phillips</i>				2. Date of Death Month Day Year <i>Jan 28 2007</i>	3. Time of Death <i>1949 M</i>	
	4a. Facility Name (If not institution, give street and number) <i>Coastal Hospice at the Lane</i>		4b. City, Town, or Location of Death <i>Salisbury</i>		4c. County of Death <i>Wicomico</i>		
Funeral Director	5. Social Security Number <i>424-54-7588</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>63 Yrs.</i>	If Under 1 Year Months Days Hours Min. <i></i>	8. Date of Birth (Month Day Year) <i>6/17/1943</i>	9. Birthplace (State or Foreign Country) <i>Georgia</i>	
	10a. State <i>Maryland</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Salisbury</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <i>208 Naylor St.</i>			10f. Zip Code <i>21804</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>Navy</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i></i>		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+) Officer</i>		16b. Kind of Business/Industry <i>U.S. Military</i>	
	17. Father's Name (First, Middle, Last) <i>Walter Phillips</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Tess Rayburn</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>James McCaig/friend</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>208 Naylor St., Salisbury, MD 21804</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Anatomy Gifts Registry</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holloway Funeral Home Professional Association</i>		Date <i>1/29/07</i>	20c. Location - City or Town, State <i>Hanover, MD</i>
	21. Signature of Funeral Service Licensee <i>David E. Thompson CFSP</i>			22. Name and Address of Facility <i>501 Snow Hill Rd., Salisbury, MD 21804</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Metastatic Lung Cancer</i>					Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Cirrhosis of the Liver</i>						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <i></i>	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i></i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i>	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>David E. Council, MD</i>			29c. License number <i>D26278</i>		29d. Date signed (Month, Day, Year) <i>1-29-07</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David E. Council, MD Coastal Hospice po Box 1733 Salisbury MD 21802</i>			32. Registrar's Signature <i>Debbie K. Spence</i>		31. Date filed (Month, Day, Year) <i>JAN 30 2007</i>	

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1/28/07
1/28/07

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 24 7

1 - For
State
Registrar

Physician
/Medical
Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month January Day 28 Year 2007				3. Time of Death 0755 M			
Doris E. Pone										
4a. Facility Name (If not institution, give street and number) <i>Peninsula Regional Medical Center</i>			4b. City, Town, or Location of Death <i>Salisbury</i>				4c. County of Death <i>Wicomico</i>			
5. Social Security Number 187-24-5576		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.			
8. Date of Birth (Month, Day, Year) 10/12/1930								9. Birthplace (State or Foreign Country) Pennsylvania		
10a. State Delaware 10b. County Sussex 10c. City, Town or Location Millville								10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 117 Hollywood Drive				10f. Zip Code 19970				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. white Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) - Ward Clerk				16b. Kind of Business/Industry Health care		
17. Father's Name (First, Middle, Last) John Smick				18. Mother's Name (First, Middle, Maiden Surname) Elsie Faix						
19a. Informant's Name/Relationship (Type, Print) Linda Rossi/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 Tareyton Dr., Langhorne, PA 19047						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park				Date 2/1/07		
21. Signature of Funeral Service Licensee <i>David H. Thompson CFSP</i>								20c. Location - City or Town, State Somerton, PA		
22. Name and Address of Facility Holloway Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804								Approximate Interval Between Onset and Death		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. Due to (or as a consequence of): <i>Hypertension</i></p> <p>b. Due to (or as a consequence of): <i>Vision</i> <i>Arteries</i> <i>Alzheimers</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Pulmonary Bronchitis</i>								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>Dr. Steven Hearne</i>	29c. License number 140715	29d. Date signed (Month, Day, Year) 1/28/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Steven Hearne 106 Miford Street Suite 605 Salisbury MD 21804</i>										
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature <i>James D. Smith</i>								

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04248

For
State
Registrar

1-

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Paul J. Paradis		Jan 28 2007		0600 AM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Archetype Nursing & Rehabilitation		Salisbury		Wicomico	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/3/1925	9. Birthplace (State or Foreign Country) Massachusetts
Usual Residence of Decedent		10a. State Maryland			10b. County Wicomico
		10c. City, Town or Location Salisbury			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1103 Schumaker Dr., Apt. 205		10f. Zip Code 21804		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4+		16b. Kind of Business/Industry Executive Officer NOAA	
17. Father's Name (First, Middle, Last) Oscar Joseph Paradis		18. Mother's Name (First, Middle, Maiden Surname) Irene Marie Beauchemin			
19a. Informant's Name/Relationship (Type, Print) Dorothy L. Paradis/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 Schumaker Dr., Apt. 205, Salisbury, MD 21804			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 2/1/07	20c. Location - City or Town, State Silver Spring, MD
21. Signature of Funeral Service Licensee Dorothy L. Paradis CFSP		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. Due to (or as a consequence of): ASLV</p> <p>b. Due to (or as a consequence of): PARKINSON</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Vet NATESAN			
		29c. License number 047094		29d. Date signed (Month, Day, Year) 1/29/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vet NATESAN 1415 S DIVISION STREET SALISBURY MD 21804					
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature John B. Thompson			

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

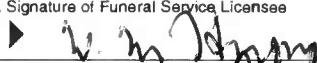
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01249

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eunice Roventini						2. Date of Death Month Jan. Day 26 Year 2007		3. Time of Death 1:20A M	
	4a. Facility Name (If not institution, give street and number) National Lutheran Home			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 067-16-8270	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 20, 1923	9. Birthplace (State or Foreign Country) New York			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Md. 10b. County Montgomery						10c. City, Town or Location Rockville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 9701- Veirs Drive			10f. Zip Code 20850			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical			16b. Kind of Business/Industry Unknown			
	17. Father's Name (First, Middle, Last) Daniel J. McGonigle						18. Mother's Name (First, Middle, Maiden Surname) Katherine Cray			
	19a. Informant's Name/Relationship (Type, Print) Jerry Roventini- Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3528-Hamstead Ct., Durham, N.C.						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Saviour Cem.			Date 1/27/2007	20c. Location - City or Town, State York, Pa.		
Medical Certifier: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Hysong Co., Inc.			22. Name and Address of Facility 2222-Wisconsin Ave., NW Wash., DC 20007			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	<p>a. Sepsis Due to (or as a consequence of):</p> <p>b. Pneumonia Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
	Approximate Interval Between Onset and Death 5 days									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. severe dementia									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 			29c. License number 0050612			29d. Date signed (Month, Day, Year) January 26, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Samuel Mailer - 9701-Veirs Dr., Rockville, Md. 20850									
	31. Date filed (Month, Day, Year) JAN 31 2007			32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Partial. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Medical Examiner, Physician/Medical Examiner, Funeral Director, Hospital or Attending Physician.

Seria Robertson

07-00629

UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

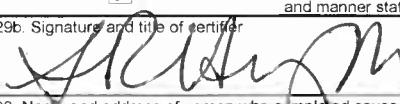
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 250

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Seria Clarissa Robertson				2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> January 23, 2007	3. Time of Death 0025 hrs	
	4a. Facility Name (if not institution, give street and number) 900 Kennebec Street		4b. City, Town, or Location of Death OXON HILL		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 212-13-9604	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 20 Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) July 6, 1986	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent 10a. State DC 10b. County Washington				10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 124 Irvington Street S.W.			10f. Zip Code 20032	10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Black Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier		16b. Kind of Business/Industry National Geographic			
17. Father's Name (First, Middle, Last) Eugene E. Robertson			18. Mother's Name (First, Middle, Maiden Surname) Clarice C Alston				
19a. Informant's Name/Relationship (Type, Print) Matilda Bennett (Grandmother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Irvington St. S.W. Washington, DC 20032				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 1/29/2007	20c. Location - City or Town, State Brentwood, MD		
21. Signature of Funeral Service Licensee Susan A. Cooper		22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Blunt Force and Sharp Force Injuries Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					Approximate Interval Between Onset and Death	
	<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) JAN 23, 2007	28b. Time of Injury 0005 hrs	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject stabbed and beaten		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Sidewalk	28f. Location (Street and Number or Rural Route Number, City or Town, State) 900 Kennebec Street, OXON HILL, MD				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 23, 2007			
30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

ORIGINAL

CRD

State
RegistrarDHMH 17 Rev 1/2001
OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 25

3. Time of Death
2305 hrs1- For State
Registrar**Physician/
Medical Examiner****Funeral
Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last) OTIS ANTHONY ROSS				2. Date of Death Month Day Year January 20, 2007	3. Time of Death 2305 hrs	
4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly		
4c. County of Death Prince George's						
5. Social Security Number 579-82-1133		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) FEB. 27 1964	
9. Birthplace (State or Foreign Country) MARYLAND						
10a. State MD 10b. County PRINCE GEORGE'S 10c. City, Town or Location COTTAGE CITY						
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 4142 BUNKER HILL ROAD				10f. Zip Code 20722	10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify		
14. Race - American Indian, Black, White, etc. BLACK		Specify				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry PRIVATE
17. Father's Name (First, Middle, Last) JAMES WESLEY				18. Mother's Name (First, Middle, Maiden Surname) NAOMI MAYNOR		
19a. Informant's Name/Relationship (Type, Print) SALIEKA BRYAN/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15802 LETCHER RD BRANDYWINE, MARYLAND 20613		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <i>K.D. Hall</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORIAL		Date 1/27/2007	20c. Location - City or Town, State RIVERDALE, MARYLAND	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last						Approximate Interval Between Onset and Death
a. Multiple Gunshot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Jan 20, 2007		28b. Time of Injury 2236 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street						28f. Location (Street and Number or Rural Route Number, City or Town, State) 4142 Bunker Hill Road, Cottage City, MD
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>Carol Allan</i>						29c. License number O.C.M.E.
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						29d. Date signed (Month, Day, Year) January 21, 2007
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature <i>Barbara B. Spotts</i>				

ORIGINAL

VOID

CERTIFICATE #

2007-04252

SEE

CERTIFICATE #

2006-43473

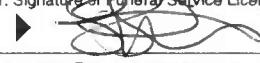
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04253

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TERRY LEE SIMMONS				2. Date of Death Month Day Year JANUARY 27 2007	3. Time of Death 9:35 A M		
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL		4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGE'S			
Funeral Director	5. Social Security Number 577-94-6382	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) MARCH 28 1963	9. Birthplace (State or Foreign Country) NORTH CAROLINA	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County PRINCE GEORGE'S 10c. City, Town or Location LANDOVER						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2100 EAST MARLBORO AVENUE # 102			10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) DISABLED			16b. Kind of Business/Industry NONE		
	17. Father's Name (First, Middle, Last) ANDREW SIMMONS			18. Mother's Name (First, Middle, Maiden Surname) ANNIE SMITH				
	19a. Informant's Name/Relationship (Type, Print) ANDREW SIMMONS/FATHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 EAST MARLBORO AVE # 102 LANDOVER, MARYLAND 20785				
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY		Date 1/31/2007	20c. Location - City or Town, State RIVERDALE, MARYLAND		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic Shock a. Due to (or as a consequence of): MULTIPLE DECUBITUS b. Due to (or as a consequence of): RESPIRATORY FAILURE c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 1 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State) At home	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D27577				29d. Date signed (Month, Day, Year) 1/27/07	
	30. Name and address of person who completed cause of death (Item 28e, Type, Print) OPHNELL CUMBERBATCH M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785							
	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner shall be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 254

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
CREOLA STRAIN		JANUARY 29 2007				1:50A M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
4736 68TH AVENUE		HYATTSVILLE				PRINCE GEORGE'S	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) DEC. 10 1953	9. Birthplace (State or Foreign Country) SOUTH CAROLINA
Usual Residence of Decedent		10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State MD		10b. County PRINCE GEORGE'S				HYATTSVILLE	
10e. Street and Number 4736 68TH AVENUE		10f. Zip Code 20784				10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry RECEPTIONIST			PRIVATE
17. Father's Name (First, Middle, Last) WYLIE MCGRIFF		18. Mother's Name (First, Middle, Maiden Surname) DORTHER MINGO					
19a. Informant's Name/Relationship (Type, Print) VERONICA MINGO/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4736 68th AVENUE HYATTSVILLE, MARYLAND 20784					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY		Date 2/2/2007	20c. Location - City or Town, State RIVERDALE, MARYLAND		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				Approximate Interval Between Onset and Death	
<p>a. METASTATIC LUNG CANCER Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) JANUARY 31, 2007	
29b. Signature and title of certifier 		29c. License number D0060863					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIKA BENNS M.D. 1221 MERCANTILE LANE UPPER MARLBORO, MARYLAND 20744							
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04255
Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Ann C. Starr			2. Date of Death Month 1 Day 29 Year 2007	3. Time of Death 11:30 A M
4a. Facility Name (If not institution, give street and number) The Hebrew Home of Greater Washington			4b. City, Town, or Location of Death Rockville	4c. County of Death Montgomery
5. Social Security Number 031-20-0332	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0
			8. Date of Birth (Month, Day, Year) 4/24/1928	9. Birthplace (State or Foreign Country) MA
Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 6121 Montrose Road			10f. Zip Code 20852	10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Jeweler		16b. Kind of Business/Industry Own Business
17. Father's Name (First, Middle, Last) Irving L. Schweber			18. Mother's Name (First, Middle, Maiden Surname) Frieda Shogel	
19a. Informant's Name/Relationship (Type, Print) Linda Starr - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630C Orchard Drive Bethesda MD 20817	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Garden of Remembrance Memorial Park			Date 1/30/07	20c. Location - City or Town, State Clarksburg MD
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): ACUTE CEREBRAL THROMBOSIS Approximate Interval Between Onset and Death 1 WEEK</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month 0 Day 0 Year 0000			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 1/29/07	28b. Time of Injury M 1	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
29c. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
29d. Date signed (Month, Day, Year) JANUARY 29, 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH D. PATEL, 6121 MONTROSE RD, ROCKVILLE, MD 20852				
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04256

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Lee Stevens					2. Date of Death Month Day Year January 29, 2007	3. Time of Death 12:15 A M
	4a. Facility Name (If not institution, give street and number) 3923 Rosewood Road			4b. City, Town, or Location of Death Monrovia		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 315-36-7722	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) July 11, 1940	9. Birthplace (State or Foreign Country) Indiana	
	Usual Residence of Decedent 10a. State Maryland			10b. County Frederick			10c. City, Town or Location Monrovia
10e. Street and Number 3923 Rosewood Road				10f. Zip Code 21770		10g. Citizen of What Country? U.S.A.	
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1957 - 1961			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Electronics	
17. Father's Name (First, Middle, Last) Roy William Stevens				18. Mother's Name (First, Middle, Maiden Surname) Bessie Mildred Sauls			
19a. Informant's Name/Relationship (Type, Print) Dorothy Mae Stevens / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3923 Rosewood Road, Monrovia, Maryland 21770			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Providence Cemetery	Date 2/2/07	20c. Location - City or Town, State Kempton, Maryland	
21. Signature of Funeral Service Licensee Heather M. Wolff				22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial INFARCTION Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ISCHEMIC CARDIOMYOPATHY CORONARY ARTERY DISEASE						
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS HYPERTENSION DYSLIPIDEMIA							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D0035857			
29b. Signature and title of certifier LESZEK KAROWIEC				29d. Date signed (Month, Day, Year) 1-30-07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LESZEK KAROWIEC 501 N. Frederick Ave, Gaithersburg MD 20878							
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature Leanne B. Apak					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Important: If Item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

10TH WA
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

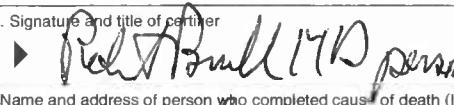
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 257

1 - For State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl Elizabeth SHANK							2. Date of Death Month JAN Day 31 Year 2007	3. Time of Death 05:48 M		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington				
Funeral Director	5. Social Security Number 214-09-0785	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 16, 1912	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Washington 10c. City, Town or Location Hagerstown							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 1132 Luther Drive			10f. Zip Code 21740			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary			16b. Kind of Business/Industry school				
	17. Father's Name (First, Middle, Last) John Robert Ground				18. Mother's Name (First, Middle, Maiden Surname) Olive B. Price						
	19a. Informant's Name/Relationship (Type, Print) Paul Shank - husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1132 Luther Drive, Hagerstown, Maryland 21740							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Cedar Lawn Mem. Park		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 2/3/07	20c. Location - City or Town, State Hagerstown, Maryland					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 12 hrs		
	<p>a. Acute Myocardial Infarction Due to (or as a consequence of):</p> <p>b. Atherosclerotic Coronary Artery Disease 15 yrs Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 		29c. License number D 04 359			29d. Date signed (Month, Day, Year) 2-1-07					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Robert Buell 1459 Potomac Ave. Hager. Md 21742										
	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

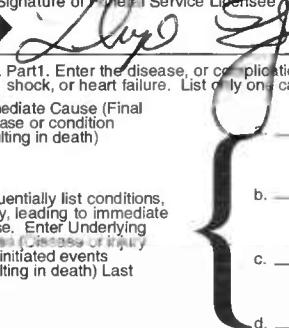
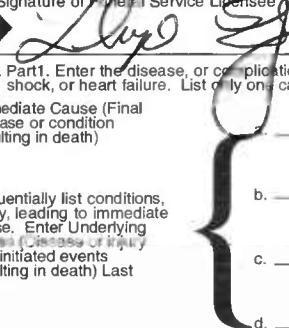
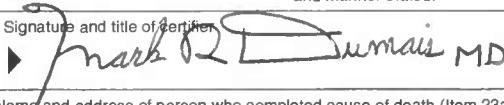
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04258

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph E. Swann					2. Date of Death Month Day Year January 29, 2007	3. Time of Death 6:17a M	
	4a. Facility Name (If not institution, give street and number) Southern MD Hospital			4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 578-48-4759	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) July 7, 1937	9. Birthplace (State or Foreign Country) WashingtonDC		
To Be Completed by Funeral Director	10a. State Maryland 10b. County Prince George 10c. City, Town or Location Brandywine					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 13240 Martin Rd			10f. Zip Code 20613	10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Driver		16b. Kind of Business/Industry DC Government			
	17. Father's Name (First, Middle, Last) Paul S. Swann			18. Mother's Name (First, Middle, Maiden Surname) Mary Edna Proctor				
	19a. Informant's Name/Relationship (Type, Print) Mary E. Swann / Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3940 Bexley PL. #616 Suitland MD 20746					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.	Date 2/5/07	20c. Location - City or Town, State Clinton MD			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility 191 Adams Funeral Home, Aquasco, MD 20608		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death		
	<p>a. Respiratory failure Due to (or as a consequence of):</p> <p>b. Pneumonia Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Medical Examiner		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 		29c. License number D0053813			29d. Date signed (Month, Day, Year) 1-31-07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark R. Dumais 7503 Surratts Rd. Clinton, MD							
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JRH

State Registrar

VOID

CERTIFICATE #

2007-04259

SEE

CERTIFICATE #

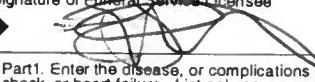
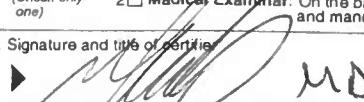
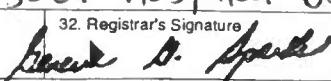
2006-43474

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04260

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERNON CALVIN THOMAS							2. Date of Death Month 01 Day 27 Year 2007		3. Time of Death 08:00 PM			
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's						
Funeral Director	5. Social Security Number 212-29-3831		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 03, 02, 1951	9. Birthplace (State or Foreign Country) Trinidad & Tobago			
To Be Completed by Funeral Director	10a. State Md		10b. County Prince George's		10c. City, Town or Location Beltsville					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 11234 Cherryhill Road # 102			10f. Zip Code 20705			10g. Citizen of What Country? U.S.A.						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Contractor		16b. Kind of Business/Industry Private								
	17. Father's Name (First, Middle, Last) Ethelbert Thomas					18. Mother's Name (First, Middle, Maiden Surname) Edith Boyce							
	19a. Informant's Name/Relationship (Type, Print) Brenda Smith Thomas/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11234 Cherryhill Road # 102 Beltsville, Maryland 20705									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National			Date 2/2/2007		20c. Location - City or Town, State Laurel, Maryland					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785										
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS								Approximate Interval Between Onset and Death				
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ISCHEMIC BOWEL												
	c. Due to (or as a consequence of): d. Due to (or as a consequence of):												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RESPIRATORY FAILURE RENAL FAILURE								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	29b. Signature and title of certifier  MD		29c. License number D0063580			29d. Date signed (Month, Day, Year) 01,27, 2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mina Yacoub 3001 Hospital Drive, Cheverly, MD												
	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 										

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

CR (5)

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04261

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELENA AYANGA TIM							2. Date of Death Month Day Year JANUARY 17 2007	3. Time of Death 9:36PM M	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE			4c. County of Death		
Funeral Director	5. Social Security Number NONE		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) MARCH 31 1944	9. Birthplace (State or Foreign Country) CAMEROON
	Usual Residence of Decedent		10a. State MD 10b. County PRINCE GEORGE'S 10c. City, Town or Location ADELPHI							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 7951 RIGGS ROAD # 6				10f. Zip Code 20783			10g. Citizen of What Country? CAMEROON		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 4+		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry TEACHER GOVERNMENT		
	17. Father's Name (First, Middle, Last) PIUS TIM				18. Mother's Name (First, Middle, Maiden Surname) CECILIA MOH					
	19a. Informant's Name/Relationship (Type, Print) VICTOR TUFOIN/BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7951 RIGGS ROAD # 6 ADELPHI, MARYLAND 20783					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) X-D. J. Hall		20b. Place of Disposition (Name of cemetery, crematory or other place) Family Plot			Date 2/9/2007	20c. Location - City or Town, State BAMENDA, CAMEROON			
	21. Signature of Funeral Service Licensee X-D. J. Hall				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYELOGENOUS LEUKEMIA								Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification; To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TUMOR LYSIS SYNDROME								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Jyoti S. Mathad		29c. License number P19773			29d. Date signed (Month, Day, Year) JANUARY 29, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JYOTI MATHAD 22 S. GREENE STREET BALTIMORE, MARYLAND 21201									
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature Barbara A. Spotts							

marquese dajour timberlake

07-00530
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 262

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) MARQUESE DAJOUR TIMBERLAKE				2. Date of Death Month <input type="text"/> January Day <input type="text"/> 19 Year <input type="text"/> 2007	3. Time of Death 1528 hrs
Funeral Director	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center			4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's
To Be Completed by Funeral Director	5. Social Security Number 214-29-7486	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 16 Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (MM/DD/YYYY) May 25, 1990	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent 10a. State MD 10b. County Montgomery			10c. City, Town or Location Burtonsville Brutonsville		
10e. Street and Number 14225 Angelton Terrace				10f. Zip Code 20866	10g. Citizen of What Country? U.S.A.	
Physician / Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) 11th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student	16b. Kind of Business/Industry Springbrook High School			
17. Father's Name (First, Middle, Last) Bobby Henry Timberlake				18. Mother's Name (First, Middle, Maiden Surname) Tabehta Weedon		
19a. Informant's Name/Relationship (Type, Print) Tabetha Weedon (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14225 Angelton Ter., Burtonsville, MD 20866		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: Parklawn Mem Pk			20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Mem Pk	Date 2/3/07	20c. Location - City or Town, State Rockville, MD	
21. Signature of Funeral Service Person George T. Shooken Jr.			22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850			
23a. Part I. Enter the disease, injury or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED #10cmperFH1/30/07, BMW, MoCo						
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) Jan 19, 2007	28b. Time of Injury 1425 hrs	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Shot by police	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street	28f. Location (Street and Number or Rural Route Number, City or Town, State) Green Castle Road, Burtonsville, MD			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number O.C.M.E.				
29b. Signature and title of certifier Carole Hallan		29d. Date signed (Month, Day, Year) January 20, 2007				
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature Barbara B. Jones				

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 263

3. Time of Death

Physician
/Medical
Examiner

1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

ANNIE THORNTON

2. Date of Death

Month

Day

Year

JANUARY 24 2007

1441 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTURE HOSPITAL

4b. City, Town, or Location of Death

Rockville

4c. County of Death

MONTGOMERY

5. Social Security Number

212-84-8378

6. Sex

M

F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 20, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

Yes No

10e. Street and Number

13406 Dove Street

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Albert Gross

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Hill

19a. Informant's Name/Relationship (Type, Print)

Lorraine Reddix (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13406 Dove St., Silver Spring, MD 20904

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ash Memorial Cem

Date

2/3/07

20c. Location - City or Town, State

Sandy Spring, MD

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
246 N. Washington St, Rockville, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. GRAM NEGATIVE ROD SEPSIS

Due to (or as a consequence of):

DAYS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome pf pregnancy
 Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify) _____
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOMYELITIS OF SACRUM

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DOA Other: Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Arijit Dasgupta, M.D.

D64444

January 24, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arijit Dasgupta, M.D. 9901 Shady Grove Road, Rockville, MD 20850

31. Date filed (Month, Day, Year)

JAN 30 2007

32. Registrar's Signature

Bruce K. Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registration

MARYLAND#10a-c, 10e, fper INF2/2/07, BMW, MCO

Certificate of Death

Reg. No.

2007 01 26

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanette Wood Talbot				2. Date of Death Month Day Year January 28, 2007	3. Time of Death 6:10 a.m.			
	4a. Facility Name (If not institution, give street and number) Manor Care-Chevy Chase		4b. City, Town, or Location of Death Chevy Chase		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 121-34-8998	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min. 0 0 24 00	8. Date of Birth (Month, Day, Year) Nov. 28, 1916	9. Birthplace (State or Foreign Country) New York			
To Be Completed by Funeral Director	10a. State MD				10b. County Montgomery	10c. City, Town or Location Chevy Chase Washington	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 8700 Jones Mill Road 1117 Jenifer Street, NW		10f. Zip Code 20815-20015		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: -		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: -		14. Race - American Indian, Black, White, etc. White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3 Registered Nurse		16b. Kind of Business/Industry Health Care				
	17. Father's Name (First, Middle, Last) Robert Walter Wood				18. Mother's Name (First, Middle, Maiden Surname) Maude Marguerite Tuthill				
	19a. Informant's Name/Relationship (Type, Print) Joan T. Prival/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4117 Jenifer Street, NW, Washington, DC 20015						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Circhew Cole		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date Jan. 29, 2007	20c. Location - City or Town, State Alexandria, Virginia			
	21. Signature of Funeral Service Licensee Circhew Cole		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. Aspiration Pneumonia Due to (or as a consequence of):</p> <p>b. Sepsis Due to (or as a consequence of):</p> <p>c. Congestive Heart Failure Due to (or as a consequence of):</p> <p>d. Asthma</p>								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right Cerebrovascular Accident, Left Hemiplegia							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Kirti Vohra, M.D.						
			29c. License number D20274		29d. Date signed (Month, Day, Year) Jan. 29, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra, M.D. 7710 Bradley Blvd., Bethesda, MD 20817		31. Date filed (Month, Day, Year) JAN 30 2007						
State Registrar	32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Hospital, please see me for Transfer Form

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04265

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Helen I. Turner</i>							2. Date of Death Month Day Year 1 26 2007 1852 M	3. Time of Death			
	4a. Facility Name (If not institution, give street and number) <i>Coastal Hospice at the Lake</i>			4b. City, Town, or Location of Death <i>Salisbury</i>			4c. County of Death <i>WICOMICO</i> DELAWARE					
Funeral Director	5. Social Security Number 222-24-7552	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 11-14-1917	9. Birthplace (State or Foreign Country) DELAWARE			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State DELAWARE 10b. County SUSSEX 10c. City, Town or Location DAGSBORO								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 33015 MAIN STREET				10f. Zip Code				10g. Citizen of What Country? US			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>If Yes, Give Year or Dates:</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Specify:</i>			14. Race - American Indian, Black, White, etc. WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)				16b. Kind of Business/Industry POSTAL CLERK				
	17. Father's Name (First, Middle, Last) JOSEPH R. WEST					18. Mother's Name (First, Middle, Maiden Surname) MARYDEL WILLIN						
	19a. Informant's Name/Relationship (Type, Print) GENEVIEVE W. PARSONS/ COUSIN			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33008 MAIN ST, DAGSBORO, DE. 19939				Date				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>►</i>			20b. Place of Disposition (Name of cemetery, crematory, or other place) DAGSBORO REDMENS MEMORIAL CEMETERY			20c. Location - City or Town, State DAGSBORO, DELAWARE					
	21. Signature of Funeral Service Licensee <i>►</i>			22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST, FRANKFORD, DE. 19945								
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>PULMONARY FIBROSIS</i>								Approximate Interval Between Onset and Death			
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>{</i>											
	a. Due to (or as a consequence of): <i>PULMONARY FIBROSIS</i>	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):								
	IF FEMALE: 23c. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>► Jav-Wood</i>			
									29c. License number <i>D14254</i>			
									29d. Date signed (Month, Day, Year) <i>1/27/07</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DELFIELD HOSPITAL</i>								31. Date filed (Month, Day, Year) JAN 31 2007			
									32. Registrar's Signature <i>James W. Wood</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important! If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04266

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death			
1- For State Registrar		Eva Cecilia Thomas	January 27 2007	3:25 PM			
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
Funeral Director		GENESIS NURSING	La Plata	Charles			
To Be Completed by Funeral Director		4d. Social Security Number	4e. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	4f. Age (In yrs. last birthday) 85 Yrs.	4g. If Under 1 Year Months Days Hours Min.	4h. Date of Birth (Month, Day, Year) 11-21-1921	4i. Birthplace (State or Foreign Country) Maryland
		5. Usual Residence of Decedent 10a. State Maryland	10b. County Charles	10c. City, Town or Location Bryantown	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 4795 Bryantown Road		10f. Zip Code 20601	10g. Citizen of What Country? USA		
		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Nurse	16b. Kind of Business/Industry Veterans Home			
		17. Father's Name (First, Middle, Last) Samuel R	18. Mother's Name (First, Middle, Maiden Surname) Thomas Viola Wills				
		19a. Informant's Name/Relationship (Type, Print) Amy Scroggins Sister	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Scroggins Street La Plata Maryland 20646				
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marys	20c. Date 21/3/07	20d. Location - City or Town, State Bryantown Maryland		
		21. Signature of Funeral Service Licensee Lily Ely	22. Name and Address of Facility 191 20605 Aquasco Rd Aquasco, Maryland 20608 Adams Funeral Home PA				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Secondary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	23b. Approximate Interval Between Onset and Death Cardio respiratory Arrest Mitral valve regurgitation				
		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
		29b. Signature and title of certifier Anil Katal MD	29c. License number 00061652	29d. Date signed (Month, Day, Year) 1/31/07			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anil Katal, Suite #304, 11350 Pemberlye St, Waldorf, MD 20603					
		31. Date filed (Month, Day, Year) JAN 31 2007	32. Registrar's Signature Karen B. Apodaca				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04267

For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

DDO 1129/07
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department. If item 27 is marked other than "natural", or items 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last)

Anna Lois Travis

2. Date of Death

Month

Day

Year

3. Time of Death

7 A

M

4a. Facility Name (If not institution, give street and number)

Homewood at Crumland Farms

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-18-1046

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Month, Day, Year

Sept. 26, 1917

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1048 Arnoldstown Rd.

10f. Zip Code

21755

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 4 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Isaac Ennis

18. Mother's Name (First, Middle, Maiden Surname)

Emma Pearson

19a. Informant's Name/Relationship (Type, Print)

Helen Colburn (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

782 Wembley Apt. F, Frederick, MD 21701

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, etc.)

Bethel Church Locust Valley Cem.

Date

20c. Location - City or Town, State

2/2/07

Middletown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD 21769

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

X days

a. Due to (or as a consequence of):

Dementia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

10016428

29d. Date signed (Month, Day, Year)

11/29/07

31. Date filed (Month, Day, Year)

JAN 31 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

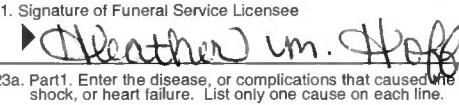
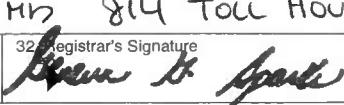
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 258

3. Time of Death

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) Margaret Vongsavang					2. Date of Death Month Day Year January 27 2007		3. Time of Death 3:07 P M			
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital					4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick			
Funeral Director		5. Social Security Number 212-64-3524		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) July 29, 1954	9. Birthplace (State or Foreign Country) Washington, D.C.	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
		10e. Street and Number 30 North Place Room 106A					10f. Zip Code 21701			10g. Citizen of What Country? U.S.A.		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry U.S. Government		
		17. Father's Name (First, Middle, Last) Eugene Weldon Orndorff					18. Mother's Name (First, Middle, Maiden Surname) Bonnie Marie Anderson					
		19a. Informant's Name/Relationship (Type, Print) Shannan Palazzo / Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4910 Damascus Road, Laytonsville, Maryland 20882					
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematorium			Date 2/1/07	20c. Location - City or Town, State Alexandria, Virginia	
		21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
<p>a. FAILURE TO THRIVE Due to (or as a consequence of): HISTORY OF LUNG CA.</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINE SEPSIS HYPERTENSION										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) At home						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner		29b. Certification: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D 47951			29d. Date signed (Month, Day, Year) 01-29-2007							
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.

5
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

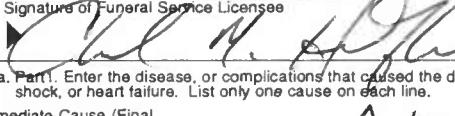
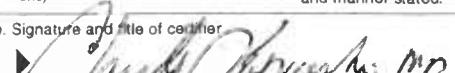
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04269
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD JAMES VERNON					2. Date of Death Month Day Year JANUARY 29, 2007	3. Time of Death 16:30 M
	4a. Facility Name (If not institution, give street and number) 8910 HIGHBANKS DRIVE			4b. City, Town, or Location of Death EASTON		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 221-18-4151	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 18, 1929	9. Birthplace (State or Foreign Country) DELAWARE
	Usual Residence of Decedent 10a. State MARYLAND			10b. County TALBOT			10c. City, Town or Location EASTON
10e. Street and Number 8910 HIGHBANKS DRIVE				10f. Zip Code 21601		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1951-1953		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL ENGINEER			16b. Kind of Business/Industry HEATING AND AIR CONDITIONING	
17. Father's Name (First, Middle, Last) ELMER D. VERNON				18. Mother's Name (First, Middle, Maiden Surname) REBECCA PARIS			
19a. Informant's Name/Relationship (Type, Print) REBECCA PETER / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 STAGWELL ROAD, QUEENSTOWN, MARYLAND 21658			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION		Date JANUARY 31, 2007	20c. Location - City or Town, State STEVENSVILLE, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FELLOWS, HELFENBEIN, AND NEWMAN FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arterosclerotic Cardiovascular Disease				Approximate Interval Between Onset and Death			
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Obstructive Pulmonary Disease							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	
		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D044282				29d. Date signed (Month, Day, Year) 1/30/07	
29b. Signature and title of certifier  Claude Koprowski, MD							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Claude Koprowski, MD 4410 Bachelor's Pt. Rd. Oxford, MD 21654							
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 27

3. Time of Death

2. Date of Death
Month Day Year
January 28, 2007

06:35A M

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)

Roy Warren Villers

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

556-44-5670

6. Sex

M

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Texas

Months

Days

Hours

Min.

Nov 30, 1935

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

Yes

No

10e. Street and Number

401 Watts Branch Parkway

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: (UNK)

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+) 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Maynard Roy Villers

18. Mother's Name (First, Middle, Maiden Surname)

Clarice Marshall

19a. Informant's Name/Relationship (Type, Print)

Gretchen S. Villers/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 Watts Branch Pkwy. Potomac, MD 20854

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

01/30/07 Beltsville, MD

21. Signature of Funeral Service Licensee

► Beverly L. Heckrotte

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

1 week

Pulmonary Embolism

a. Due to (or as a consequence of):

Subarachnoid Hemorrhage

3 weeks

b. Due to (or as a consequence of):

Pneumonia

3 days

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Qimesh A. Shah MD

29c. License number

DO64415

29d. Date signed (Month, Day, Year)

JANUARY 28 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIMESH SHAH MD 9901 MEDICAL CENTER DRIVE ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

JAN 30 2007

32. Registrar's Signature

Sean A. Shah

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04271

For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
PEARL WATSON		JAN 26 2007				2:20 AM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
WASHINGTON ADVENTIST		TAKOMA PARK				MONTGOMERY	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 1-28-1918	9. Birthplace (State or Foreign Country) ARKANSAS
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
MD	PRINCE GEORGES	ADEPHI					
10e. Street and Number 1801 MEZOROT RD		10f. Zip Code 20783				10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 5 YRS		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 YRS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAID		16b. Kind of Business/Industry HOTEL			
17. Father's Name (First, Middle, Last) DAVE GIPSON		18. Mother's Name (First, Middle, Maiden Surname) LUCINDA BOWERS					
19a. Informant's Name/Relationship (Type, Print) OSCAR WATSON / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8416 20TH AVE ADEPHI MD 20783		Date			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL		20c. Location - City or Town, State SUITLAND MD			
21. Signature of Funeral Service Licensee Juanita		22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME LLC 3015 10TH STREET NW, SUITLAND DC 20056		Approximate Interval Between Onset and Death wks			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter mode of death such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23d. Date of delivery Month Day Year			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
{		a. RESISTANT SEPSIS Due to (or as a consequence of): b. RESPIRATORY FAILURE Due to (or as a consequence of): c. DEMENTIA Due to (or as a consequence of): d.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D-17874		29d. Date signed (Month, Day, Year) 1-27-2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. M. NAYAR MD, 3717-38 th AV COTTAGE CITY, MD 20722							
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Barbara D. Sparta					

**Physician/
Medical Examiner**

**Funeral
Director**

**1- For State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01 27

		1. Decedent's Name (First, Middle, Last) Carson Wise, III				2. Date of Death Month Day Year January 25, 2007	3. Time of Death 1731 hrs
		4a. Facility Name (if not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery
		5. Social Security Number 0759 213-41-0579	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 13	If Under 1 Year Months Days Hours Min. Yrs.	8. Date of Birth (MM/DD/YYYY) Nov. 27, 1993	9. Birthplace (State or Foreign Country) Washington D.C.
		10a. State D.C.		10b. County Washington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		10e. Street and Number 1248 Hamlin Street N.E.			10f. Zip Code 20017		10g. Citizen of What Country? United States
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. Black
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry Education
		17. Father's Name (First, Middle, Last) Carson Eugene Wise, II			18 Mother's Name (First, Middle, Maiden Surname) Rosie Green		
		19a. Informant's Name/Relationship (Type, Print) Carson Eugene Wise, II/Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1248 Hamlin Street N.E. Washington, D.C. 20017		
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: <i>Keith George Moyer</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date Jan. 31, 2007	20c. Location - City or Town, State Suitland, Md.
		21. Signature of Funeral Service Licensee <i>Alexander S. Pope, P.A.</i>		22. Name and Address of Facility 5538 Marlboro Pike/Forestville, Md. 20747			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Anomalous origin of left coronary artery from right sinus		Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death	
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other:			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc.		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 26, 2007	
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature <i>John B. Graci</i>	

Medical Certification: To Be Completed by Physician/Medical Examiner

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04273

1- For State Registrar Amended # 5 per Inf.gc, 2/9/07

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Calvin Jamie Wills				2. Date of Death Month Day Year January 25, 2007		3. Time of Death 1:28 A M	
Funeral Director		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
To Be Completed by Funeral Director		5. Social Security Number 573-56-8735	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. Hours Min. 	8. Date of Birth (Month, Day, Year) August 28, 1943	9. Birthplace (State or Foreign Country) Washington, D.C.	
To Be Completed by Funeral Director		10a. State Maryland				10b. County Prince Georges		10c. City, Town or Location District Heights	
To Be Completed by Funeral Director		10e. Street and Number 2320 Roslyn Avenue				10f. Zip Code 20747		10g. Citizen of What Country? United States	
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Feb. 1960 Feb. 1964		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Howard University			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Calvin Coolidge Wills				18. Mother's Name (First, Middle, Maiden Surname) Elaine Catherine Taylor			
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Althea Marie Moyd Wills (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 Roslyn Avenue; District Heights, Maryland 20747			
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Randolph B. Wills		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Cheltenham Veterans Cemetery		Date Feb. 5, 2007	20c. Location - City or Town, State Cheltenham, Maryland		
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee Randolph B. Wills				22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011			
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest				Approximate Interval Between Onset and Death More than 5 days			
To Be Completed by Physician/Medical Examiner		b. Delayed Cardiopulmonary Due to (or as a consequence of): Underlying Cause				 " " "			
To Be Completed by Physician/Medical Examiner		c. Respiratory Failure Due to (or as a consequence of): Bronchopneumonia				3 weeks			
To Be Completed by Physician/Medical Examiner		d. Bronchopneumonia				3 months			
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis Bacteremia Gastroenteritis				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 				28f. Location (Street and Number or Rural Route Number, City or Town, State) 			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier John Doe MD			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Doe MD 1450 Penn Ave. #18 Upper Marlboro, MD 20772				29c. License number D-20824			
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature John Doe				29d. Date signed (Month, Day, Year) 1/25/07	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04274

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nadine Julie Walsh						2. Date of Death Month <u>January</u> Day <u>27</u> Year <u>2007</u>	3. Time of Death <u>3:45 PM</u>	
	4a. Facility Name (If not institution, give street and number) Doctors Hospital			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number <u>503-28-8482</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>74</u> Yrs.	If Under 1 Year Months <u></u> Days <u></u>	If Under 24 Hrs. Hours <u></u> Min. <u></u>	8. Date of Birth (Month, Day, Year) <u>Dec 21 1932</u>	9. Birthplace (State or Foreign Country) <u>Canada</u>		
	Usual Residence of Decedent 10a. State <u>Maryland</u> 10b. County <u>Prince Georges</u>			10c. City, Town or Location Bowie			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <u>13509 Old Chapel Road</u>			10f. Zip Code <u>20720</u>			10g. Citizen of What Country? <u>United States</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <u>Spec white</u>	
	15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12) 12</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>auditor</u>			16b. Kind of Business/Industry <u>US Government</u>		
	17. Father's Name (First, Middle, Last) <u>Helmer Olacer Jacobson</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Geneva Bolin</u>					
	19a. Informant's Name/Relationship (Type, Print) <u>David J, Walsh - husband</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13509 Old Chapel Rd. Bowie, MD 20720</u>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>Brausch</u>			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Chesapeake Highlands</u>			Date <u>Jan 31 2007</u>	20c. Location - City or Town, State <u>Port Republic Maryland</u>	
	21. Signature of Funeral Service Licensee <u>Brausch</u>			22. Name and Address of Facility <u>Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676</u>					
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): <u>Non Small Cell Carcinoma of Right Lung</u></p> <p>b. Due to (or as a consequence of): <u>Right lung Atalectasis</u></p> <p>c. Due to (or as a consequence of): <u>Advanced Chronic obstructive肺 Disease 720 yr</u></p> <p>d. Due to (or as a consequence of): <u>Infarction of Right Basal Ganglion</u></p> <p>Approximate Interval Between Onset and Death <u>Aug. 06</u> <u>Dec 06</u> <u>Dec 06</u></p>								
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____</p> <p>23d. Date of delivery Month Day Year</p> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertensive Heart Disease</u> <u>Atrial Fibrillation.</u> <u>ASPIRATION PNEUMONIA RIGHT LUNG</u></p> <p>23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <u>S. S. Dabir, MD</u>			29c. License number <u>D21200</u>			29d. Date signed (Month, Day, Year) <u>JAN 27 2007</u>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SHRINIVAS R. UDAPIN 7245B HANOVER PKWY GREENBELT MD 20770</u>								
State Registrar	31. Date filed (Month, Day, Year) <u>JAN 30 2007</u>			32. Registrar's Signature <u>Jesus B. Aponte</u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04275

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Austin C. J. Wiles		January 28 2007		7:45 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Fahrney Keedy Nursing Home		Boonsboro		Washington
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days Hours Min.
220-34-1069				
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		
Mar. 22, 1917		MD		
Usual Residence of Decedent				
10a. State MD	10b. County Washington	10c. City, Town or Location Boonsboro		
10e. Street and Number 7507 Mapleville Rd.		10f. Zip Code 21713		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 8		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farmer		16b. Kind of Business/Industry farm owner
17. Father's Name (First, Middle, Last) Russell P. Wiles Sr.		18. Mother's Name (First, Middle, Maiden Surname) Letha Grossnickel		
19a. Informant's Name/Relationship (Type, Print) Charles Wiles (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 67 Hillcrest Dr., Boonsboro, MD 21713		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Donald B. Thompson Funeral Home		20b. Place of Disposition (Name of cemetery, crematory or other place) Grossnickle Cem.		Date 2/1/2007
21. Signature of Funeral Service Licensee Khalid Waseem		20c. Location - City or Town, State Myersville, MD		
22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death line.				
Immediate Cause (Final disease or condition resulting in death) a. Meumonia Due to (or as a consequence of):				
b. Diabetes mellitus Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. _____				
Approximate Interval Between Onset and Death 1 w				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
26. Place of Death (Check only one)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Yes 9 <input type="checkbox"/> No				
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier DR KHALID WASEEM				
29c. License number 052323				
29d. Date signed (Month, Day, Year) 01-29-2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR KHALID WASEEM 1126 OVAL CT. HAGERSTOWN, MD. 21740		32. Registrar's Signature James H. Smith		
31. Date filed (Month, Day, Year) JAN 31 2007				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 06 276

1- For State Registrar

1. Decedent's Name (First, Middle, Last)

Marshall Lee Williams

2. Date of Death

Month

Day

Year

3. Time of Death

0934 hrs

Physician/Medical Examiner**Funeral Director**

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**1- For State Registrar**

4a. Facility Name (if not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

214-70-7029

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months

If Under 24 Hrs

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

Jan. 6, 1957

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1: Yes 2: No

10e. Street and Number

1639 Edgewood circle

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Poultry laborer

16b. Kind of Business/Industry

Perdue

17. Father's Name (First, Middle, Last)

William Leon Batson

18. Mother's Name (First, Middle, Maiden Surname)

Dorthea Williams

19a. Informant's Name/Relationship (Type, Print)

Dorthea Cephas / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Interfaith ave. Federalsburg, Md. 21632

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State4 Donation 5 Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Federal Hill Ceme.

Date

2/3/07

20c. Location - City or Town, State

Federalsburg, Md.

21. Signature of Funeral Service Licensee

Dr. M. Smith

22. Name and Address of Facility

Bennie Smith Funeral Home

917 W. Isabella st. Salisbury, Md. 21801

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Artery Plaque Rupture

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26 Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther: 4 Nursing Home 5 Residence 6 Other

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending Investigation6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

Carol Allan

Carol Allan, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 22, 2007

31. Date filed (Month, Day, Year)

JAN 29 2007

32. Registrar's Signature

*Carole Hallan***State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

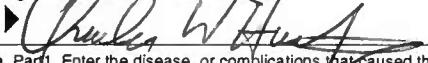
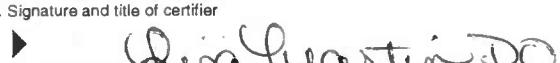
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04277

Reg. No.

1-
For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maude S. Wilkins							2. Date of Death Month JAN. Day 28 Year 2007	3. Time of Death 6:15 AM
	4a. Facility Name (If not institution, give street and number) ROSLIE'S LOVING CARE			4b. City, Town, or Location of Death WILLARDS			4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 215-05-3844	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) APR. 20, 1909	9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent									
10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location WILLARDS					
10e. Street and Number 7407 CANAL STREET				10f. Zip Code 21874				10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) SEAMSTRESS				16b. Kind of Business/Industry MANUFACTURING	
17. Father's Name (First, Middle, Last) JAMES E. WILKINS					18. Mother's Name (First, Middle, Maiden Surname) CHARLOTTE ELIZABETH BRADFORD				
19a. Informant's Name/Relationship (Type, Print) ELAINE W. PERDUE/NIECE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 5, WILLARDS, MARYLAND 21874					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) NEW HOPE CEMETERY			Date 1/31/07	20c. Location - City or Town, State WILLARDS, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure									
Approximate Interval Between Onset and Death									
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown									
23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
24a. Was an autopsy performed? 1 Yes 2 No									
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No									
25. Was case referred to medical examiner? 1 Yes 2 No									
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Living									
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide									
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No									
28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 									
29c. License number C20005747									
29d. Date signed (Month, Day, Year) Jan. 29, 2007									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa Martin, DO 201 Laurel Rd. Millsboro DE 19966									
31. Date filed (Month, Day, Year) JAN 29 2007					32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04278

1. For State Registrar

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last) James J. Ague	2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> February 13, 2007	3. Time of Death 2054 hrs
--	---	-------------------------------------

Funeral Director

4a. Facility Name (if not institution, give street and number) BWI Airport	4b. City, Town, or Location of Death Hanover	4c. County of Death Anne Arundel
--	--	--

5. Social Security Number 192-18-5533	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. 0 0 0 0	8. Date of Birth (MM/DD/YYYY) July 6, 1925	9. Birthplace (State or Foreign Country) PA
---	---	--	--	--	---

Usual Residence of Decedent			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10a. State PA	10b. County Allegheny	10c. City, Town or Location Allison Park	

10e. Street and Number 4150 Timberlane Drive	10f. Zip Code 15101	10g. Citizen of What Country? USA
--	-------------------------------	---

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. White Specify:
---	---	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Salesman	16b. Kind of Business/Industry Printing Supplies
--	---	--

17. Father's Name (First, Middle, Last) James J. Ague Sr.	18. Mother's Name (First, Middle, Maiden Surname) Marcella R. Teichman
---	--

19a. Informant's Name/Relationship (Type, Print) Dona Ague / Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4150 Timberlane Drive, Allison Park, PA 15101
---	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) National Cemetery Of Alleghenies	Date 02/20/2007	20c. Location - City or Town, State Cecil Township, PA
--	---	---------------------------	--

21. Signature of Funeral Service Licensee Dona W. Marshall	22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Lung/Throat Carcinoma Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
--	--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	
--	--	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year
---	--	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	---

23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
--	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	---	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
---	--

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 15, 2007
--	--	---

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature
--	---	-------------------------------

Baltimore, MD 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04279

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 4:00 a m
Sabina Avrett		Feb 8, 2007				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
Frederick Villa Nursing Center		Baltimore				Baltimore
5. Social Security Number 212-32-3782	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jul 4, 1907	9. Birthplace (State or Foreign Country) No. Carolina
Usual Residence of Decedent 10a. State Maryland		10b. County Howard		10c. City, Town or Location Jessup		
10e. Street and Number 7320 Wye Avenue			10f. Zip Code 20794		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1950		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) John Henry Taylor			18. Mother's Name (First, Middle, Maiden Surname) Sally A. Taylor			
19a. Informant's Name/Relationship (Type, Print) Cornelia Moore Granddaughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 Clifton Avenue Baltimore, Maryland 21216			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Estep Brothers Funeral Service, P.A.		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Park Cemetery		Date 02/15/07	20c. Location - City or Town, State Laurel, Maryland	
21. Signature of Funeral Service Licensee Debil A. Estep SA		22. Name and Address of Facility Estep Brothers Funeral Service, P.A. 1300 Eutaw Place Baltimore, Md 21217				
23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE TO THRIVE						
Approximate Interval Between Onset and Death						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. Due to (or as a consequence of): ADVANCED DEMENTIA</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Rodolfo Fernández Attorney		29c. License number DOO50303			29d. Date signed (Month, Day, Year) 02/12/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 N Rolling Rd Suite 205 Catonsville MD 21228 - Rodolfo Fernández						
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Rodolfo Fernández				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #2, per PHYS., G864, 2/15/07 WS

State of Maryland / Department of Health and Mental Hygiene

2007 04280

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

		Certificate of Death												
		Reg. No.												
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death			
	LILIA DIANE ARMSTRONG							February Day Year			4:00 P M			
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death						
	The Johns Hopkins Hospital				Baltimore City			N/A						
5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)		If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		
217-77-3316		1 □ M 2 X F		0 Yrs.		Months 1		Days 11		Hours Min.		Dec. 28, 2006 MARYLAND		
Usual Residence of Decedent														
10a. State		10b. County		10c. City, Town or Location									10d. Inside City Limits	
MARYLAND		HARFORD		ABERDEEN									1 □ Yes 2 X No	
10e. Street and Number					10f. Zip Code					10g. Citizen of What Country?				
4747 CORALBERRY CT.					21001					U.S.A.				
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.					
1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced			1 □ Yes 2 X No If Yes, Give Year or Dates:			1 □ Yes 2 X No Specify:			Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry					
Elementary/Secondary (0-12) N/A				College (1-4 or 5+) N/A					N/A					
17. Father's Name (First, Middle, Last)							18. Mother's Name (First, Middle, Maiden Surname)							
TODD ARMSTRONG							NANCY ARMSTRONG							
19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Todd Armstrong/Father					4747 Coralberry Ct., Aberdeen, Md., 21001									
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State				
1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				METRO CREMATORIAL				02-13-07		BALTIMORE, MARYLAND				
21. Signature of Funeral Service Licensee														
► John Deam														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
Approximate Interval Between Onset and Death														
Immediate Cause (Final disease or condition resulting in death) 42 days														
Cardiorespiratory Failure														
Due to (or as a consequence of):														
Sequential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
Hypoplastic Left Heart Disease 42 days														
b. Due to (or as a consequence of):														
c. Due to (or as a consequence of):														
d. Due to (or as a consequence of):														
IF FEMALE:		23c. If yes, outcome pf pregnancy												
23b. Was decedent pregnant in the past 12 months?		1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of delivery						
1 □ Yes 2 □ No 9 □ Unknown		9 □ Unknown						Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
Prematurity, Chronic lung disease, intraventricular hemorrhage														
23e. Did tobacco use contribute to the cause of death?														
1 □ Yes 2 □ No 3 □ Probably 4 X Unknown														
24a. Was an autopsy performed?														
24b. Were autopsy findings available prior to completion of cause of death?														
1 □ Yes 2 X No														
25. Was case referred to medical examiner?		26. Place of Death (Check only one)												
1 □ Yes 2 X No		Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA					Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
27. Manner of Death		28a. Date of Injury (Month, Day Year)			28b. Time of Injury			28c. Injury at Work?		28d. Describe how injury occurred				
1 X Natural 5 □ Pending investigation		M			M			1 □ Yes 2 □ No						
2 □ Accident 6 □ Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
3 □ Suicide 4 □ Homicide														
29a. Certifier (Check only one)		29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
2 X Certifying Physician		29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier		29c. License number					29d. Date signed (Month, Day, Year)							
► Theodora A. Stavroudis MD		RES-000					February 8, 2007							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
Theodora A. Stavroudis, MD 600 North Wolfe Street, Baltimore, Maryland 21201														
31. Date filed (Month, Day, Year)		32. Registrar's Signature												
FEB 15 2007		John Deam												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 0428

1- For State
RegistrarPhysician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1715 hrs
Shawn Michael Albright	February 8, 2007	

4a. Facility Name (if not institution, give street and number)
106 Water Fountain Way Apt # 1024b. City, Town, or Location of Death
Glen Burnie4c. County of Death
Anne ArundelFuneral
Director

5. Social Security Number 214-94-9673	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Sept 18, 1964	9. Birthplace (State or Foreign Country) MD
--	--	---	---	--	--

Usual Residence of Decedent

10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
------------------	-----------------------------	--	--

10e. Street and Number
1127 McHenry Drive10f. Zip Code
2106110g. Citizen of What Country?
U.S.A.

11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify white	14. Race - American Indian, Black, White, etc.
--	---	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Wire Binder	16b. Kind of Business/Industry Westinghouse
--	---	--

17. Father's Name (First, Middle, Last)
Edward H. Albright, Sr.18. Mother's Name (First, Middle, Maiden Surname)
Mary Lou Harvey

19a. Informant's Name/Relationship (Type, Print) Edward H. Albright/Brother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Snow Fall Way Westminster MD 21157
--	---

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: West Arundel Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2-13-2007	20c. Location - City or Town, State Odenton, Maryland
---	---	--

21. Signature of Funeral Service Licensee <i>Danielle J. Laucke</i>	22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227
--	---

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 2a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Diphenhydramine intoxication Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
--	--	--	--

<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	#25a,27,28a-f, per ME, g865, 3/2/07 TT
---	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

23f. Did alcohol contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Fnd 2/8/2007	28b. Time of Injury Fnd 5:00 pm	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unk.
---	--	------------------------------------	---	---

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) scene	28f. Location (Street and Number or Rural Route Number, City or Town, State) 106 Water Fountain Way Apt # 102 Glen Burnie, MD
---	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier <i>Theodore M. King Jr., MD.</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 9, 2007
---	---------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
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31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature <i>Jane K. Jones</i>
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State
Registrar

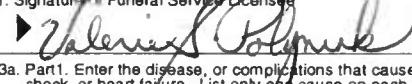
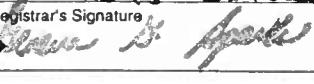
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04282

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year			3. Time of Death 10:50 A M	
	Naomi M.		Bridges		February 10, 2007					
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	Genesis Eldercare			Brooklyn Park			Anne Arundel			
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) July 29, 1927	9. Birthplace (State or Foreign Country) Maryland	
212-22-1152			79							
Usual Residence of Decedent										
10a. State	10b. County	10c. City, Town or Location						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Maryland	Anne Arundel	Pasadena								
10e. Street and Number 8476 Main Ave.				10f. Zip Code 21122				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner / Bookkeeper		16b. Kind of Business/Industry Chesapeake Marine Co.						
17. Father's Name (First, Middle, Last) Bruce H. Sturm (Son)		18. Mother's Name (First, Middle, Maiden Surname) Rogers Lillian Inez Richardson								
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101 Poplar Ridge Road Pasadena, Maryland 21122								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Pk.		Date 2/13/07		20c. Location - City or Town, State Elkridge Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCullly-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. Myocardial Infarction Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease Due to (or as a consequence of):</p> <p>c. Hypertension Due to (or as a consequence of):</p> <p>d.</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
29b. Signature and title of certifier 		29c. License number DS53462				29d. Date signed (Month, Day, Year) 2/12/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Munesa MD 7845 Oakwood Road Glen Burnie MD 21061										
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007

01-283

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Yolanda A. Boston						2. Date of Death Month 02 Day 10 Year 2007		3. Time of Death 10:49 AM			
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital			4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 219-04-7795	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 37	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Feb. 2, 1970	9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	10a. State Md.			10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	10e. Street and Number 5489 Moores Run Drive			10f. Zip Code 21206			10g. Citizen of What Country? USA					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard 0		16b. Kind of Business/Industry Balto. City							
	17. Father's Name (First, Middle, Last) Earl Boston			18. Mother's Name (First, Middle, Maiden Surname) Geraldine Turner								
	19a. Informant's Name/Relationship (Type, Print) (Step-Father) Mr. Michael Evans			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5489 Moores Run Drive Balto. Md. 21206								
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► Joseph L. Russ		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		Date 2/17/2007	20c. Location - City or Town, State Lansdowne, Md.						
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Joseph L. Russ			22. Name and Address of Facility Joseph L. Russ Funeral Home, P.A. 2222 W. North Ave. Balto. Md. 21216								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adult Respiratory Distress Syndrome									Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of): Pneumonia											
	c. Due to (or as a consequence of):											
	d. Due to (or as a consequence of):											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Interstitial Fibrosis Pulmonary Chronic Respiratory Failure Diabetes Mellitus										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier Philip F. Panzarella, MD		29c. License number D0036643			29d. Date signed (Month, Day, Year) 2/11/07						
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Philip F. Panzarella									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04284

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

2-5-07 615am
 Department of Health and Mental Hygiene
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

Physician /Medical Examiner

To Be Completed by Physician/Medical Examiner

James Black,
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death
JAMES C. BLACK		Feb 5 2007				2:40PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
EAST POINT NURSING CENTER						BAL TO.
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11-6-37	9. Birthplace (State or Foreign Country) S.C.
10a. State Md.		10c. City, Town or Location BAL TO.				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 308 S. ROBINSON ST.		10f. Zip Code 21224				10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK.
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry CONSTRUCTION
17. Father's Name (First, Middle, Last) Jim BLACK			18. Mother's Name (First, Middle, Maiden Surname) FANNIE BYRD			
19a. Informant's Name/Relationship (Type, Print) Bonnie BLACK			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 S. ROBINSON ST. BAL TO. 21224			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MT CARMEL		Date	20c. Location - City or Town, State Dundalk Md.
21. Signature of Funeral Service Licensee Wesley Davis			22. Name and Address of Facility WESLEY DAVIS JR. F.H. 2007 EASTERN AVE. BAL TO.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
<p>Immediate Cause (Final disease or condition resulting in death) COPD</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
Approximate Interval Between Onset and Death						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D43725				
29b. Signature and title of certifier Dr Tariq MAHMOUD		29d. Date signed (Month, Day, Year) 2-10-07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Tariq MAHMOUD 2300 Dulany Valley Rd Timonium Md 21093						
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Anne B. Spangler				

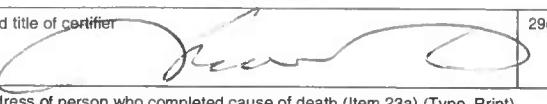
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04285

1- For State Registrar

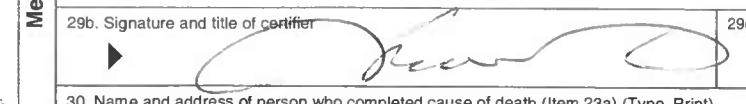
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JEANNE WIEMAN BORGES							2. Date of Death Month FEBRUARY Day 14 , Year 2007	3. Time of Death 03:00P M	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 213-20-4441	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) September 29, 1919	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Towson 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number 8422B Charles Valley Court			10f. Zip Code 21204			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) George Arnold Wieman				18. Mother's Name (First, Middle, Maiden Surname) Katherine Floyd					
	19a. Informant's Name/Relationship (Type, Print) Susan Borges McGehee			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Kenneth Square Baltimore, Maryland 21212						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory			Date 2/15/07	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee <i>Connie McGehee Kenakis</i>		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212							
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death	
	a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC CONGESTIVE HEART FAILURE								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	MULTIPLE MYOLOMA								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number D37254			29d. Date signed (Month, Day, Year) 2-14-07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON POH LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204									
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04286

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 7:30 a M	
		Nathaniel L. Burrell		Feb 11, 2007			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
744 Grantley Street		Baltimore		N/A			
5. Social Security Number 216-36-6991		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 15, 1940	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number 744 Grantley Street		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled		16b. Kind of Business/Industry Baltimore City			
17. Father's Name (First, Middle, Last) George W. Burrell		18. Mother's Name (First, Middle, Maiden Surname) Annie Hooks					
19a. Informant's Name/Relationship (Type, Print) Charda Burrell Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 West Belvedere Avenue Baltimore, Maryland 21239					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Cecilia Estep SR		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date	20c. Location - City or Town, State Catonsville, Maryland		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease				Approximate Interval Between Onset and Death years			
Severally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease					
		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive Pulmonary Disease				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D32158		29d. Date signed (Month, Day, Year) 2/12/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jyoti Parikh, MD 821 N. Eutaw Street, ste 407, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Bevin L. Jones					

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 287

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death M
MARGARET Virginia Byrd		02 10 2007		12 49
4a. Facility Name (If not institution, give street and number) Bon Secours Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
5. Social Security Number 216-28-9928	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age in yrs. last birthday 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore
10e. Street and Number 1826 W. Lexington St		10f. Zip Code 21223		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Psychiatric Nurse		16b. Kind of Business/Industry Spring Grove Hosp
17. Father's Name (First, Middle, Last) Thomas Dickerson		18. Mother's Name (First, Middle, Maiden Surname) Madeleine Young		
19a. Informant's Name/Relationship (Type, Print) Walter Byrd Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1826 Lexington St Baltimore Md 21223		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Cemetery		Date 2/17/07	20c. Location - City or Town, State Arbutus Md
21. Signature of Funeral Service Licensee DeWayne		22. Name and Address of Facility Chatman - Harris Funeral Home		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause per each line. Immediate Cause (Final disease or condition resulting in death)		23b. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)		Approximate Interval Between Onset and Death
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure Hypertension		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29b. Signature and title of certifier H. Neal Reynolds		29c. License number D27163		29d. Date signed (Month, Day, Year) 02-10-2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Neal Reynolds, Bon Secours Hospital of Baltimore				
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature James B. Foster		

State
Registrar

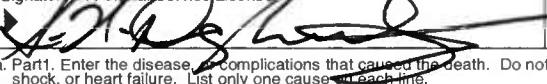
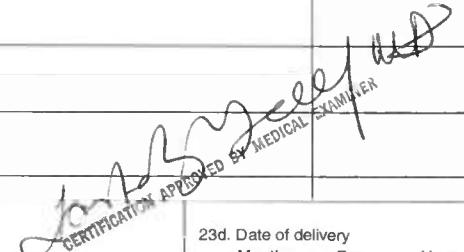
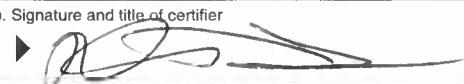
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 8 per fh,g878,04/11/08dhp Certificate of Death

Reg. No. 2007 04288

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JEAN BUCKLEY						2. Date of Death Month 2 Day 13 Year 2007	3. Time of Death 1602 M
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death	
Funeral Director	5. Social Security Number 216-28-8357	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) 01/17/1933	9. Birthplace (State or Foreign Country) MARYLAND	
To Be Completed by Funeral Director	10a. State MD. 10b. County Anne Arundel 10c. City, Town or Location MILLERSVILLE						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8366 Brookwood Rd.			10f. Zip Code 21108			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME	
	17. Father's Name (First, Middle, Last) IRVIN DUVAIL						18. Mother's Name (First, Middle, Maiden Surname) ELLA FORSYTHE	
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLES E. BUCKLEY, Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8366 BROOKWOOD RD. MILLERSVILLE, MD. 21108			Date	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ANATOLY GAFIS REGISTRY 2-15-07			20c. Location - City or Town, State HANOVER, MD.	
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122	
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause per each line. TRAUMATIC BRIAN INJURY						Approximate Interval Between Onset and Death 24 hrs	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)						23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						 CERTIFICATION APPROVED BY MEDICAL EXAMINER	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						28a. Date of Injury (Month, Day Year) 2/12/07	
	28b. Time of Injury Unknown M						28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Home						28d. Describe how injury occurred FALL DOWN STAIRS	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 	
	29c. License number 17377						29d. Date signed (Month, Day, Year) 2/13/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REGINALD BURTON MD 22 S. GREENE ST. BALTIMORE, MD 21201							
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature 				

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04289

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Elma Bawtinhimer							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 8:34 A M	
	4a. Facility Name (If not institution, give street and number) 144 Fairmont Drive				4b. City, Town, or Location of Death Bel Air			4c. County of Death Harford		
Funeral Director	5. Social Security Number 062-18-6704	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Apr. 17, 1925	9. Birthplace (State or Foreign Country) New York			
Usual Residence of Decedent 10a. State Maryland 10b. County Harford 10c. City, Town or Location Bel Air 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
To Be Completed by Funeral Director	10e. Street and Number 144 Fairmont Drive				10f. Zip Code 21014			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Homemaker			
	17. Father's Name (First, Middle, Last) Clayton Albert Wacker			18. Mother's Name (First, Middle, Maiden Surname) Gertrude Emma Miller						
	19a. Informant's Name/Relationship (Type, Print) Bryan Bawtinhimer/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2637 Laurel Valley Garth, Abingdon, Maryland 21009						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hilltop Service Corp.			20b. Place of Disposition (Name of cemetery, crematory or other place) 2-13-07			Date Towson, Maryland	20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression									23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 			29c. License number D43204			29d. Date signed (Month, Day, Year) 2/13/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gillian Adams 104 Plumtree Rd Bel Air Md 21015									
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
For Amend #20b Per FH G864 2/21/07 JH
1- Certificate of Death
Reg. No. 0007 04290
State Registrar

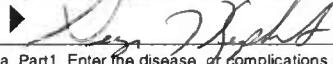
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert H. Brown							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 9:00 PM
	4a. Facility Name (If not institution, give street and number) Alfred House			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-90-8289	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) October 13, 1927	9. Birthplace (State or Foreign Country) England		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery				10c. City, Town or Location Chevy Chase			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 130 Hesketh Street				10f. Zip Code 20815		10g. Citizen of What Country? Canada		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 11 Drill Sergeant			16b. Kind of Business/Industry Canadian Government		
	17. Father's Name (First, Middle, Last) Hugh Brown				18. Mother's Name (First, Middle, Maiden Surname) Violet Maud Lloyd				
	19a. Informant's Name/Relationship (Type, Print) Jean Alexandra Tuttle/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Hesketh Street, Chevy Chase, Maryland 20815				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Montgomery Crematorium, Inc.		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.			Date February 17	20c. Location - City or Town, State Bethesda, Maryland		
	21. Signature of Funeral Service Licensee Angeleene Bennett		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Month Year
	<p>a. Pulmonary Failure Due to (or as a consequence of):</p> <p>b. Renal Insufficiency Due to (or as a consequence of):</p> <p>c. Congestive Heart Failure Due to (or as a consequence of):</p> <p>d. Metastatic Adenocarcinoma of Colon</p>								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, Arthritic Knees, Flexion Contractors of Knees								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Group Home			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D25410			29d. Date signed (Month, Day, Year) February 12, 2007			
	29b. Signature and title of certifier Oliver Lawless								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oliver Lawless, MD 18111 Prince Philip Drive, Olney, Maryland 20832								
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04291
Reg. No.

1- For State Registrar		2. Date of Death Month Day Year										3. Time of Death													
		February 10, 2007										3:15 PM M													
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last)										4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death							
		Marjorie Louise Blankenbaker										Brooke Grove Rehab & Nursing Center				Sandy Spring				Montgomery					
Funeral Director		5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)		If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)											
		015-14-3961		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		86 Yrs.		Months		Days		Hours		Min.		February 17, 1920 Massachusetts									
To Be Completed by Funeral Director		Usual Residence of Decedent												10a. State				10b. County		10c. City, Town or Location				10d. Inside City Limits	
		Maryland Montgomery Sandy Spring												Maryland				Montgomery		Sandy Spring				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number												10f. Zip Code				10g. Citizen of What Country?							
		18131 Slade School Road												20860				United States							
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.																	
		<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		Specify: White																	
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry																			
		Elementary/Secondary (0-12) 12		College (1-4 or 5+) Homemaker		Own Home																			
		17. Father's Name (First, Middle, Last)												18. Mother's Name (First, Middle, Maiden Surname)											
		Leslie Washburn												Lotte Barstow											
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State													
		Robert Blankenbaker/Son		5213 Continental Drive Rockville, Maryland 20853		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Hebron Lutheran Church Cemetery		February 17, 2007		Madison, Virginia													
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501																			
				M00335																					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death											
		Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____												1 Hour											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year																			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)		27. Manner of Death		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
				Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide																			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
		29b. Signature and title of certifier 		29c. License number D33700		29d. Date signed (Month, Day, Year)																			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)																							
		Ted E. Howe, M.D. 18100 Slade School Road, Sandy Spring, Maryland 20860																							
		31. Date filed (Month, Day, Year)		32. Registrar's Signature																					
		FEB 15 2007																							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or if Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 29

For
State
Registrar

1- Decedent's Name (First, Middle, Last)

David Emil Chester Sr.

2. Date of Death
Month Day Year
February 10, 2007

3. Time of Death
7:00 AM

Physician
/Medical
Examiner

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1311 Saratoga Drive

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

213-36-4463

6. Sex

M

F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year
Months Days Hours Min.

8. Date of Birth
(Month, Day, Year)

Feb. 21, 1940

9. Birthplace (State or Foreign Country)

Maryland

Baltimore, Maryland 21215-0036
Usa
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

Yes No

10e. Street and Number

1311 Saratoga Drive

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married

Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **White**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steamfitter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Benjamin (mn) Chester

18. Mother's Name (First, Middle, Maiden Surname)

Rose (mn) Podruchny

19a. Informant's Name/Relationship (Type, Print)

Carolyn Chester/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1311 Saratoga Drive, Bel Air, Maryland 21014

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Darlington Cemetery

Date

2-16-07

20c. Location - City or Town, State

Darlington, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

McComas Funeral Home, P. A.

1317 Cokesbury Rd., Abingdon, Maryland 21009

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

4 months

Metastatic lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No

Unknown

23c. If yes, outcome of pregnancy

Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)

Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown



24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Yes No



25. Was case referred to medical examiner?

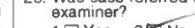
Yes No

Hospital:

Inpatient ER/Outpatient DOA

Other:

Nursing Home Residence Other (Specify)



27. Manner of Death

Natural

Accident

Suicide

Homicide

Pending investigation

Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

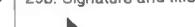
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D54841

29d. Date signed (Month, Day, Year)

2/12/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

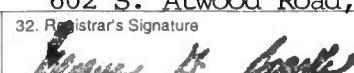
Ashkan Bahrani, MD

602 S. Atwood Road, Bel Air, MD 21014

31. Date filed (Month, Day, Year)

FEB 15 2007

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04293

1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Pao Chen Chi

2. Date of Death
Month Day Year
February 13, 2007

3. Time of Death
21:35 M

Physician
/Medical
Examiner

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

307-06-8700

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 2, 1921

9. Birthplace (State or Foreign Country)

China

To Be Completed by Funeral Director

Usual Residence of Decedent
Maryland Montgomery Rockville
10e. Street and Number
1225 Maple Grove Lane
10f. Zip Code
20850
10g. Citizen of What Country?
China

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify:
Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Jun Sun Shen

18. Mother's Name (First, Middle, Maiden Surname)

Lian Yin Chou

19a. Informant's Name/Relationship (Type, Print)

Chiali Tsai / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1225 Maple Grove Ln., Rockville, Maryland 20850

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc. 2007

Date
Feb. 18,

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

► X.E. Wilks

22. Name and Address of Facility

Robert A. Pumfrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Final
disease or condition
resulting in death)

Approximate
Interval Between
Onset and Death

a. Aspiration Pneumonia

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Urinary Tract Infection

24a. Was an autopsy performed?
1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide

5 Pending investigation
6 Could not be determined

28a. Date of Injury
(Month, Day Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► J. Wilks

29c. License number

D0063195

29d. Date signed (Month, Day, Year)

February 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven D. Wilks, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

FEB 15 2007

32 Registrar's Signature

Jean S. Smith

Baltimore, Maryland 21215-0036

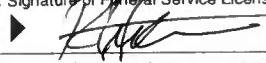
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend #26 Per FH G864 2/15/07 JH Certificate of Death
Reg. No. 2007 04294
For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louisa Elizabeth Campbell						2. Date of Death Month Day Year February 9, 2007	3. Time of Death 4:30AM	
	4a. Facility Name (If not institution, give street and number) 204 Coldbrook Road			4b. City, Town, or Location of Death Timonium			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212-20-3024	6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 13, 1922	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Glen Burnie						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 515 Dogwood Drive			10f. Zip Code 21061			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchandiser			16b. Kind of Business/Industry Greeting Cards		
	17. Father's Name (First, Middle, Last) Louis Harle				18. Mother's Name (First, Middle, Maiden Surname) Mary Rudolph				
	19a. Informant's Name/Relationship (Type, Print) Ms. Patricia Campbell/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Coldbrook Road Timonium, MD 21093				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) M01411		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem.Park		Date Feb. 12, 2007	20c. Location - City or Town, State Glen Burnie, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as, cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic adenocarcinoma of breast						Approximate Interval Between Onset and Death 3 months		
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {								
	a. Due to (or as a consequence of): Metastatic adenocarcinoma of breast								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Daughter's Residence						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number D17873			29d. Date signed (Month, Day, Year) February 9, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall A. Levine 6569 North Charles St. Towson, MD 21204								
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

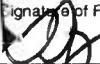
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04295

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLOSSIE RUTH CLARK							2. Date of Death Month Day Year FEB. 13, 2007	3. Time of Death 7:55 A M
	4a. Facility Name (If not institution, give street and number) Westminster Nursing Home			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 298-18-6654	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 2/10/1914	9. Birthplace (State or Foreign Country) WEST VIRGINIA		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County CARROLL 10c. City, Town or Location WESTMINSTER							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1234 WASHINGTON RD.			10f. Zip Code 21157			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry HOME MAKER		
	17. Father's Name (First, Middle, Last) JOHN			18. Mother's Name (First, Middle, Maiden Surname) CRUMP ELIZABETH			JONES		
	19a. Informant's Name/Relationship (Type, Print) RICHARD CLARK - SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 RED BIRD LANE, GETTYSBURG, PA 17325					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ASHLEY UNION CEM.			20b. Place of Disposition (Name of cemetery, crematory or other place) ASHLEY UNION CEM.			Date 2/13/07	20c. Location - City or Town, State ASHLEY, OHIO	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A.			254 E. MAIN ST., WESTMINSTER, MD 21157		
	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 years	
	<p>a. Cerebrovascular Accident Due to (or as a consequence of):</p> <p>b. Arteriosclerotic Vascular Disease Due to (or as a consequence of):</p> <p>c. Advanced age Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D25443			29d. Date signed (Month, Day, Year) 2/13/2007		
	29b. Signature and title of certifier 								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton MD 688 Park Rd, Westminster, MD 21157								
	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 296

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

Hattie Douglas
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death 7:48P M
Hattie Douglas							February 09, 2007	
4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death	
Maryland General Hospital				Baltimore City			NA	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 2 19 126	9. Birthplace (State or Foreign Country) SC	

Usual Residence of Decedent			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10a. State MD	10b. County NA	10c. City, Town or Location Baltimore					
10e. Street and Number 606 Cumberland Street			10f. Zip Code 21217	10g. Citizen of What Country? USA			

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 Cook	16b. Kind of Business/Industry Local Restaurants
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17. Father's Name (First, Middle, Last) Lewis Simon		18. Mother's Name (First, Middle, Maiden Surname) Roena Bradford
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19a. Informant's Name/Relationship (Type, Print) Ms. Ronetta Douglas - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1610 Northwick Road - Baltimore, MD 21218
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Faith Memorial Gardens	Date	20c. Location - City or Town, State Darlington, S.C.
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21. Signature of Funeral Service Licensee ► Patelle S. Harris, L.M.	22. Name and Address of Facility 3222 W. North Avenue Baltimore, MD 21216
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
a. Due to (or as a consequence of): Myocardial Infarction		
b. Due to (or as a consequence of): Sepsis		
c. Due to (or as a consequence of): Cerebrovascular Accident		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
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24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier ► M. Merattee	29c. License number 89574	29d. Date signed (Month, Day, Year) February 09, 2007
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryam Merattee, M.D. c/o Maryland General Hospital	31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature Anna B. Spaulding
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Division or Vital Records, P.O. Box 68760, ey.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04297

Reg. No.

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jerry Allen Dawson							2. Date of Death Month February Day 9 , Year 2007	3. Time of Death 6:59 A M
	4a. Facility Name (If not institution, give street and number) 950 Palladi Drive							4b. City, Town, or Location of Death Arbutus	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 215-20-6610		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) Sept 7, 1927	9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent 10a. State MD		10b. County Baltimore	10c. City, Town or Location Arbutus					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 950 Palladi Drive				10f. Zip Code 21227			10g. Citizen of What Country? U.S. A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give 1945-1948 Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Assembly		16b. Kind of Business/Industry Electronics				
	17. Father's Name (First, Middle, Last) Jacob David Dawson				18. Mother's Name (First, Middle, Maiden Surname) Anna May Jolly				
	19a. Informant's Name/Relationship (Type, Print) Mary W. Dawson/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 950 Palladi Drive Baltimore MD 21227				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Mary W. Dawson</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial Park		Date 2-14-2007	20c. Location - City or Town, State Sykesville, Maryland			
	21. Signature of Funeral Service Licensee <i>Cherie Nohora</i>								
Physician /Medical Examiner	22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227								
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)								
	23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Chris Park, M.D.</i>								
	29c. License number D 0056316								
	29d. Date signed (Month, Day, Year) 21/12/2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chris Park, M.D. 1141 Security Blvd. Baltimore, MD 21244								
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature <i>Cherie Nohora</i>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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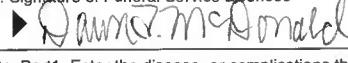
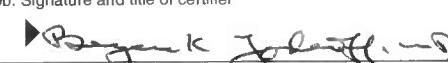
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verb., G864, 02/15/07dms
Certificate of Death

Reg. No. 2007 04298

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clinton David Dodson						2. Date of Death Month FEB. Day 2 Year 2007	3. Time of Death 9:45a M
	4a. Facility Name (If not institution, give street and number) 20313 Middletown Road			4b. City, Town, or Location of Death Freeland			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 225-34-0290	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day, Year) OCT. 24, 1916	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent 10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Gwynn Oak	
10e. Street and Number 6907 Windsor Mill Road				10f. Zip Code 21207		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Mechanical Engineer			16c. Kind of Business/Industry Service Industry	
17. Father's Name (First, Middle, Last) Fred Mack Dodson				18. Mother's Name (First, Middle, Maiden Surname) Alice Mae Grimes				
19a. Informant's Name/Relationship (Type, Print) David Lee Dodson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20313 Middletown Road Freeland, MD 21053-9628			Date	20c. Location - City or Town, State Eldersburg, MD	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park			20c. Location - City or Town, State 2/10/07			
21. Signature of Funeral Service Licensee 								
22. Name and Address of Facility Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400)								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Approximate Interval Between Onset and Death								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): Congestive Heart Failure b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastatic Adenocarcinoma of the prostate.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Son's Residence								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 020807		29d. Date signed (Month, Day, Year) 2/21/07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Benjamin Yorkoff VA Medical Center 10 N Greene St Baltimore MD 21201								
31. Date filed (Month, Day, Year) FEB 06 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

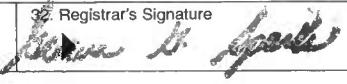
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04299

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard E. Edwards						2. Date of Death Month Day Year February 8, 2007	3. Time of Death 5:50 P M		
	4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 239-12-5630	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) November 2, 1921	9. Birthplace (State or Foreign Country) North Carolina			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland									
	10b. County Montgomery	10c. City, Town or Location Rockville						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 4077 Norbeck Square Drive			10f. Zip Code 20853			10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Engineer			16b. Kind of Business/Industry National Broadcasting Company				
	17. Father's Name (First, Middle, Last) Raymond W. Edwards				18. Mother's Name (First, Middle, Maiden Surname) Mary Lee Bobbitt					
	19a. Informant's Name/Relationship (Type, Print) Dorothy L. Edwards / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4077 Norbeck Square Drive, Rockville, Maryland 20853						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			Date February 16, 2007	20c. Location - City or Town, State Silver Spring, Maryland		
	21. Signature of Funeral Service Licensee  M01305				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) Sepsis									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia									
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number 00057124			29d. Date signed (Month, Day, Year) 2/9/07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D. 9715 Medical Center Drive, #201, Rockville, Maryland 20850									
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 							

Edwards, Richard 01/01/07 1740
Division or Vital Records, P.O. Box 68760, re

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 300

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Harris C Eichen</i>							2. Date of Death Month <i>February</i> Day <i>11</i> Year <i>2007</i>	3. Time of Death <i>12:15AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>N/A</i>			
Funeral Director	5. Social Security Number <i>224-52-3112</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91</i> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	If Under 24 Hrs. <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <i>01/09/1916</i>	9. Birthplace (State or Foreign Country) <i>NY</i>			
To Be Completed by Funeral Director	10a. State <i>MD</i> 10b. County <i>ANNE ARUNDEL</i> 10c. City, Town or Location <i>SEVERNA PARK</i>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>348 DUN ROBBIN DRIVE</i>			10f. Zip Code <i>21146</i>			10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1946</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>MILITARY OFFICER</i>			16b. Kind of Business/Industry <i>U.S. ARMED FORCES</i>			
	17. Father's Name (First, Middle, Last) <i>JOSEPH</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>EICHEN BESSIE Trott</i>						
	19a. Informant's Name/Relationship (Type, Print) <i>PAULINE EICHEN / WIFE</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>348 DUN ROBBIN DRIVE - SEVERNA PARK, MD 21146</i>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>ARLINGTON NAT'L CEM.</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ARLINGTON NAT'L CEM.</i>			Date <i>03/15/2007</i>			
	21. Signature of Funeral Service Licensee <i>Jay Clay Jr.</i>			22. Name and Address of Facility <i>SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</i>			20c. Location - City or Town, State <i>FT. MEYER, VA</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Severe Aortic Stenosis</i>							Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of): <i>Underlying Disease</i>									
	c. Due to (or as a consequence of): <i>Unknown</i>									
	d. Due to (or as a consequence of): <i>None</i>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Peripheral Vascular Disease</i>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
							28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29b. Signature and title of certifier <i>Romina Thomas</i>			29c. License number <i>P18559</i>			29d. Date signed (Month, Day, Year) <i>February 11 2007</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Romina Thomas 22 South Greene Street Baltw, MD 21201</i>									
Medical Certification: To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <i>FEB 15 2007</i>			32. Registrar's Signature <i>Romina Thomas</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04301

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, W.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Isaiah Fullard		February 11 2007		1534 PM			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
Sinai Hospital of Baltimore		Baltimore City		NA			
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-32-0163			69			7/26/37	SC
Usual Residence of Decedent		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?			
1705 W. North Avenue		21217		USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 0		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Worker	
						16b. Kind of Business/Industry Apartment Complexes	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
Allen Fullard		Jacey Fullard					
19a. Informant's Name/Relationship (Type, Print) Ms Dolly Boyd (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 W. North Avenue - Baltimore, MD - 21217					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Date 2/19/2007	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Patelle S. Harris L.M.		22. Name and Address of Facility Joseph L. Russ F/H PA 2222 W. North Avenue, Baltimore MD - 21216					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. Due to (or as a consequence of): Acute myocardial Infarction							
b. Due to (or as a consequence of): Anemia							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
		9/Unknown					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Mohamed S. Ali		29c. License number DS5327		29d. Date signed (Month, Day, Year)		February 11, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHABARATI S. Ali		31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Patelle S. Harris		33. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2401 West Belvedere Avenue Baltimore, Maryland 21215	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04302

Reg. No.

1-
For
State
Registrar

Physician
/Medical
Examiner

		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year		3. Time of Death	
		Katherine Virginia Flowers				February 12 2007		6 PM	
		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
		CORIPLN @ Riverside		Belcamp		Harford			
Funeral Director		5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 76	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jun. 29, 1930	9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10a. State Maryland	10b. County Harford	10c. City, Town or Location Joppa					
		10e. Street and Number 3026 Clayton Rd.		10f. Zip Code 21085		10g. Citizen of What Country? USA			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Operator		16b. Kind of Business/Industry Telephone Company			
		17. Father's Name (First, Middle, Last) William (nmn) Golden				18. Mother's Name (First, Middle, Maiden Surname) Opal (nmn) (unk)			
		19a. Informant's Name/Relationship (Type, Print) Peggy Shunk/POA				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6918 Williams Drive, Tampa, Florida 33634			
		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gdns		Date	20c. Location - City or Town, State Bel Air, Maryland		
		21. Signature of Funeral Service Licensee ► R. M. Hahn				22. Name and Address of Facility McComas Funeral Home P. A. 50 W. Broadway, Bel Air, Maryland 21014			
		23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death			
		a. Malignant Melanoma with Pulmonary Metastasis Due to (or as a consequence of):							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. _____							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Dementia				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D19583				29d. Date signed (Month, Day, Year) February 13 2007	
		29b. Signature and title of certifier ► Nanci Lazarus MD		29c. License number D19583				29d. Date signed (Month, Day, Year) February 13 2007	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nanci Lazarus MD		32. Registrar's Signature Leanne K. Becker					
		31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Leanne K. Becker					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Eye

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04303

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Carl Farmer							2. Date of Death Month Day Year February 9, 2007	3. Time of Death 11:22 AM		
	4a. Facility Name (If not institution, give street and number) 1122-F Spalding Drive			4b. City, Town, or Location of Death Bethel Air			4c. County of Death Harford				
Funeral Director	5. Social Security Number 216-18-9593	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) March, 23 1924	9. Birthplace (State or Foreign Country) Indiana		
	Usual Residence of Decedent 10a. State Maryland								10b. County Harford	10c. City, Town or Location Bethel Air	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 1122-F Spalding Drive			10f. Zip Code 21014			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Unknown			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Purchasing Manager				16b. Kind of Business/Industry Can Company			
17. Father's Name (First, Middle, Last) Unknown					18. Mother's Name (First, Middle, Maiden Surname) Mary M. Sheets						
19a. Informant's Name/Relationship (Type, Print) Christina Farmer / Spouse					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122-F. Spalding Drive Bethel Air, MD 21014						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BS				20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Gifts Registry			Date February 9, 2007	20c. Location - City or Town, State Hanover, MD			
21. Signature of Funeral Service Licensee BS				22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P, Hanover, MD 21076							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HL2HIMAR'S Disease 3.yr. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cancer of Liver. 20 yrs Aga.											
a. Due to (or as a consequence of): HL2HIMAR'S Disease				b. Due to (or as a consequence of): Cancer of Liver.				c. Due to (or as a consequence of): 			
d. Due to (or as a consequence of): 											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred 					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 		28f. Location (Street and Number or Rural Route Number, City or Town, State) 							
29b. Signature and title of certifier PA Farmer		29c. License number D14221		29d. Date signed (Month, Day, Year) 2-9-07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. A. Farmer no 223 B - Blvd Balt MD 21221											
31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature Janet K. Foster								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 304

1- For State
RegistrarPhysician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1656 hrs
Henry S. Fretz	February 12, 2007	

4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center	4b. City, Town, or Location of Death Salisbury	4c. County of Death Wicomico
---	---	---------------------------------

93/1
Funeral
Director

5. Social Security Number 159-30-6579	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. 8. Date of Birth (MM/DD/YYYY) Nov. 2, 1935	9. Birthplace (State or Foreign Country) PA
--	--	---	---	---	--

Usual Residence of Decedent

10a. State PA	10b. County Lehigh	10c. City, Town or Location Zionsville	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
------------------	-----------------------	---	--

10e. Street and Number 8047 Yeakel Road	10f. Zip Code 18092	10g. Citizen of What Country? United States
--	------------------------	--

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White	14. Race - American Indian, Black, White, etc.
--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5	16b. Kind of Business/Industry Farmer
--	---	--

17. Father's Name (First, Middle, Last) Augustus H. Fretz	18. Mother's Name (First, Middle, Maiden Surname) Adele Steele
--	---

19a. Informant's Name/Relationship (Type, Print) Joan M. Fretz - Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8047 Yeakel Road, Zionsville, PA 18092
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Nisky Hill Cemetery	Date 2-17-2007	20c. Location - City or Town, State Bethlehem, PA
---	---	-------------------	--

21. Signature of Funeral Service Licensee <i>Zabiullah Ali, M.D.</i>	22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227
---	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Closed head injury complicating hypertensive atherosclerotic
Due to (or as a consequence of): cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

 UNPENDED AMENDED #23a,27,28a-f, per ME, g866, 4/24/07 TT

IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown24a. Was an autopsy performed?
1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No25. Was case referred to medical examiner?
1 Yes 2 NoHospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident
3 Suicide 6 Could not be determined
4 Homicide28a. Date of Injury (Month, Day, Year)
Feb. 5, 2007 28b. Time of Injury
unk. 28c. Injury at Work?
1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) other scene 28d. Describe how injury occurred
Driver involved in motor vehicle crash29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29b. Signature and title of certifier
Zabiullah Ali, M.D. 29c. License number
O.C.M.E. 29d. Date signed (Month, Day, Year)
February 13, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)
FEB 15 2007 32. Registrar's Signature
Henry S. Fretz

ORIGINAL

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 04305

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter E. Faison							2. Date of Death Month Day Year February 12, 2007	3. Time of Death 11:30 AM
	4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 214-28-4028	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) January 10, 1926	9. Birthplace (State or Foreign Country) North Carolina		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Potomac 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number 11904 Henry Fleet Drive			10f. Zip Code 20854			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Policy Analyst			16b. Kind of Business/Industry Federal Government		
	17. Father's Name (First, Middle, Last) Hayward Renick Faison				18. Mother's Name (First, Middle, Maiden Surname) Lucy Wickman Fitzhugh				
	19a. Informant's Name/Relationship (Type, Print) Myra Toel Faison / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11904 Henry Fleet Drive, Potomac, Maryland 20854				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) M01305			20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park	Date February 17, 2007	20c. Location - City or Town, State Rockville, Maryland			
	21. Signature of Funeral Service Licensee Angela Bennett				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. <i>Severe pulmonary hypertension</i> Due to (or as a consequence of):</p> <p>b. <i>Severe hypoxemia</i> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
	Approximate Interval Between Onset and Death								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cor pulmonale</i> <i>Congestive heart failure</i>								
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Gita C. Bakhshi, M.D.								
	29c. License number Q23170								
	29d. Date signed (Month, Day, Year) February 12, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gita C. Bakhshi, M.D. 9406 Old Georgetown Road, Bethesda, Maryland 20814								
	31. Date filed (Month, Day, Year) FEB 15 2007								
	32. Registrar's Signature Janet L. Faison								

ORIGINAL

Baltimore, Maryland 21215-0036
Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760, E9
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Faison E. Feb. 12, 2007
11:30 AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 10a-c, 10e-g per INF. G865, 3/15/07, JS

State of Maryland / Department of Health and Mental Hygiene

2007 04306

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

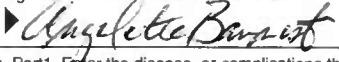
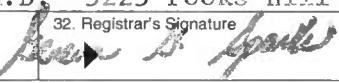
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year		3. Time of Death		
		Ruth Fears				February 12, 2007		12:55 AM		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death				
11511 Farmland Drive		Rockville				Montgomery				
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
052-01-6108			95			July 24, 1911	New York			
Usual Residence of Decedent										
10a. State Maryland		10b. County Montgomery	10c. City, Town or Location Rockville Bridgewater						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
New Jersey		Somerset								
10e. Street and Number 11511 Farmland Drive		10f. Zip Code 20852 06807				10g. Citizen of What Country? U.S.A. United States				
915 Country Club Road										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry				
Elementary/Secondary (0-12)		College (1-4 or 5+) 2				Secretary		Church		
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)								
Chester Alan Henrichs		Emma Magdalena Racquet								
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Edward W. Sauer /Son-in-law		11511 Farmland Drive, Rockville, Maryland 20852								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
		Pluckemin Cemetery		February 17, 2007		Pluckemin, New Jersey				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805								
		M01305								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Ischemic Cardiomyopathy						Approximate Interval Between Onset and Death 3 Months		
		Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Coronary Atherosclerosis						10 Years		
		Due to (or as a consequence of):								
c.		Due to (or as a consequence of):								
d.		Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paroxysmal Atrial Fibrillation						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Residence								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D0011921				29d. Date signed (Month, Day, Year)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
John A. Galotto, M.D., 5225 Pooks Hill Road, #1A, Bethesda, Maryland 20814										
31. Date filed (Month, Day, Year)		32. Registrar's Signature 								
FEB 15 2007										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a per dr., G864, 02/15/07/dhp

Certificate of Death

Reg. No. 2007 04 307

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dr. Orlando F. Furno				2. Date of Death Month Day Year January 31 2007		3. Time of Death 1:40 P M								
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A								
Funeral Director	5. Social Security Number 532-26-1289	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	if Under 1 Year Months 0	if Under 24 Hrs. Days 0	Hours 0	Min. 0								
To Be Completed by Funeral Director	10a. State MD		10b. County N/A	10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	10e. Street and Number 14 Charlote Place				10f. Zip Code 21218			10g. Citizen of What Country? USA							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1930 - 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: white							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Educator		16b. Kind of Business/Industry Baltimore City										
	17. Father's Name (First, Middle, Last) Louis Furno				18. Mother's Name (First, Middle, Maiden Surname) Maria Juliano										
	19a. Informant's Name/Relationship (Type, Print) Imogene P. Furno / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Charlote Place; Baltimore, MD 21218										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dulaney Valley Meml Gardens		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 2/6/07	20c. Location - City or Town, State Timonium, MD									
	21. Signature of Funeral Service Licensee Peter U. Asha		22. Name and Address of Facility Ruck Towson Funeral Home		1050 York Road Towson, MD 21204										
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Minutes						
	<table border="1"> <tr> <td>a. Aspiration Terminal Aspiration Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b. Coronary Artery Disease Due to (or as a consequence of):</td> <td>>20 years</td> </tr> <tr> <td>c. Hypertension Due to (or as a consequence of):</td> <td>>30 years</td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table>								a. Aspiration Terminal Aspiration Due to (or as a consequence of):		b. Coronary Artery Disease Due to (or as a consequence of):	>20 years	c. Hypertension Due to (or as a consequence of):	>30 years	d. _____
a. Aspiration Terminal Aspiration Due to (or as a consequence of):															
b. Coronary Artery Disease Due to (or as a consequence of):	>20 years														
c. Hypertension Due to (or as a consequence of):	>30 years														
d. _____															
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown				23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) January 31 2007		28b. Time of Injury M 1	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred									
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, MD									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number AT2438946						29d. Date signed (Month, Day, Year) January 31, 2007							
29b. Signature and title of certifier Manohar Asha, M.D.															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asha Manohar, M.D. Union Memorial Hospital, MD															
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Leanne D. Sparto													

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28af show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04308

1- For
State
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES E. GREEN							2. Date of Death Month 02	Day 08	Year 2007	3. Time of Death 4:45 AM
	4a. Facility Name (If not institution, give street and number) 16 S. PATTERSON PARK AVE.			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death DC				
Funeral Director	5. Social Security Number 579-38-3942	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 04/01/1928	9. Birthplace (State or Foreign Country)				
	Usual Residence of Decedent MD			10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 16 S. PATTERSON PARK AVE.			10f. Zip Code 21231			10g. Citizen of What Country? USA				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc.	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4TH			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISHWASHER			16b. Kind of Business/Industry RESTURANT				
	17. Father's Name (First, Middle, Last) LEE GREEN			18. Mother's Name (First, Middle, Maiden Surname) ESTELLE GREEN							
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BARBARA WARNER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1922 E. LOMBARD ST., BALTIMORE, MD 21231							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>ST. John cemetery 2-22-07</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Beltsville md			Date 2007-09	20c. Location - City or Town, State EASTERN AVE., BALTIMORE, MD			
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. Due to (or as a consequence of): Lung Cancer				Approximate Interval Between Onset and Death 1yr.
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23d. Date of delivery Month Day Year							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M			28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred Domestic				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 7500 North Point Rd. Baltimore, MD 21219					
29b. Signature and title of certifier Robert Dart MD			29c. License number D39460			29d. Date signed (Month, Day, Year) February 9, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Dart 7500 North Point Rd. Baltimore, MD 21219		31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature James B. Smith							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the MEDICAL EXAMINER must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

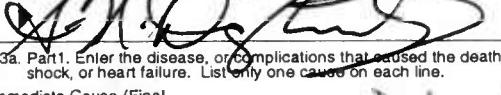
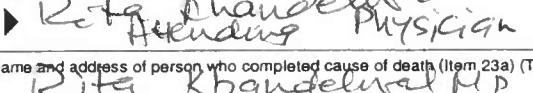
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04309

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) ALPHA GRIFFITH						2. Date of Death Month 02 Day 11 Year 2007		3. Time of Death 5:50 PM		
Funeral Director		4a. Facility Name (If not institution, give street and number) North Arundel Health & Rehab			4b. City, Town, or Location of Death Glen Burnie			4c. County of Death Anne Arundel				
		5. Social Security Number 318-42-8525		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 86 Yrs.	If Under 1 Year Months		If Under 24 Hrs. Days Hours Min.		8. Date of Birth (Month, Day, Year) 4-16-20		
		9. Birthplace (State or Foreign Country) Virginia		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Funeral Director		Usual Residence of Decedent Mrs. Anne Arundel Pasadena			10c. City, Town or Location Pasadena			10f. Zip Code 21122			10g. Citizen of What Country? U.S.A.	
		10e. Street and Number 402 LILYBROOK Ct.		10f. Zip Code 21122			10g. Citizen of What Country? U.S.A.					
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 19		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
		17. Father's Name (First, Middle, Last) LOUIS MINOR			18. Mother's Name (First, Middle, Maiden Surname) Emily Duncan							
		19a. Informant's Name/Relationship (Type, Print) Jerry D. Griffith, Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 LILYBROOK Ct. Pasadena, MD. 21122				
		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 1 Burial			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial PK. a-15-07 Elkridge, MD.			Date				
		21. Signature of Funeral Service licensee 			22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road Pasadena, MD. 21122							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Refusal to eat or drink										
		Approximate Interval Between Onset and Death 1 wk.										
Medical Certification: To Be Completed by Physician/Medical Examiner		23b. If female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury : At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 029873			29d. Date signed (Month, Day, Year) 02/12/07					
		29b. Signature and title of certifier  Rita Chandavel Physician		29c. License number D 029873			29d. Date signed (Month, Day, Year) 02/12/07					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Chandavel MD, 313 Hospital Dr., Glen Burnie Md. 21061										
State Registrar		31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b, c, per H, G864, 2720707 WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04310

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John A. Holliday							2. Date of Death Month Day Year February 14, 2007	3. Time of Death 2:25 AM
	4a. Facility Name (If not institution, give street and number) Glen Burnie Health and Rehabilitation			4b. City, Town, or Location of Death Glen Burnie			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 233-09-5584	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days Hours Min.			8. Date of Birth (Month, Day, Year) Sept 21, 1912	9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent 10a. State W. Virginia		10b. County JEFFERSON	10c. City, Town or Location CHARLESTOWN Charleston			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 44 New Sycamore Circle #117				10f. Zip Code 25414		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW 2		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry Bakery Supply Salesman			17. Father's Name (First, Middle, Last) Daniel Fred Holliday	18. Mother's Name (First, Middle, Maiden Surname) Nettie Mae Ashley
	19a. Informant's Name/Relationship (Type, Print) Patricia Ann Smith (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1988 Poplar Ridge Rd., Pasadena, Md. 21122		Date			20c. Location - City or Town, State Baltimore, Maryland	
Medical Certification: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bayview Crematory, Inc.		20b. Place of Disposition (Name of cemetery, crematory or other place) 2/15/07		20c. Location - City or Town, State Baltimore, Maryland				
	21. Signature of Funeral Service Licensee Kevin E Ecker		22. Name and Address of Facility McCully-Polyuniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 21122						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): CORONARY ARTERY DISEASE		Approximate Interval Between Onset and Death 5 YEARS					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): ESSENTIAL HYPERTENSION		Approximate Interval Between Onset and Death 20 YEARS					
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23f. Date of delivery Month Day Year		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D14160		29d. Date signed (Month, Day, Year) FEBRUARY 15, 2007					
29b. Signature and title of certifier Harjit Singh MD		29c. License number D14160		29d. Date signed (Month, Day, Year) FEBRUARY 15, 2007					
30. Name And Address of person who completed cause of death (Item 29a) (Type, Print) HARJIT SINGH M.D. 5110-A RITCHIE HIGHWAY, BALTIMORE, MD. 21225		31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature June B. Felt					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, **21**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tent.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04311

1- For State
RegistrarPhysician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

State
Registrar

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 1612 hrs			
		<i>William F. HARRINGTON</i>		February 10, 2007					
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death					
Johns Hopkins Hospital		Baltimore							
5. Social Security Number		6. Sex <i>1 M 2 F</i>		7. Age (In yrs. last birthday) <i>46</i> Yrs.		If Under 1 Year Months Days Hours Min.			
<i>220-76-5601</i>									
10a. State <i>Md.</i>		10b. County		10c. City, Town or Location <i>BALTO.</i>		10d. Inside City Limits <i>1 Yes 2 No</i>			
10e. Street and Number <i>3540 E. FEDERAL ST</i>				10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>CHAUFER</i>		16b. Kind of Business/Industry <i>TAXICAB</i>					
17. Father's Name (First, Middle, Last) <i>DANIEL GREGORY</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>ANITA BELL</i>							
19a. Informant's Name/Relationship (Type, Print) <i>CANDACE CORNETT</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>306 S. Lehigh ST. BALTO. 21224</i>							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Wesley Chavis</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>BAYVIEW CREM. 2-15-07</i>		Date <i>2-15-07</i>		20c. Location - City or Town, State <i>DUNDAK MD.</i>			
21. Signature of Funeral Service Licensee <i>Wesley Chavis</i>		22. Name and Address of Facility <i>WESLEY CHAVIS JR. ET AL. 3007 EASTERN BALTO. MD.</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): a. <i>Cocaine and oxycodone intoxication</i> <i>Hypertensive Atherosclerotic Cardiovascular Disease</i>		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b.		Due to (or as a consequence of):					
c.		Due to (or as a consequence of):		d.					
<input type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED		#23a,27,28a-f, perME,g867, 5/10/07 TT					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26 Place of Death (Check only one) Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: <i>unk</i>		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <i>Feb 2/10/2007</i>		28b. Time of Injury <i>Frd 03:30 pm</i>		28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred <i>found in trailer</i>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>3540 E. Federal St. Baltimore, MD</i>	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Patricia Aronica-Pollak MD.</i>		29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>February 11, 2007</i>					
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner		111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) <i>FEb 15 2007</i>		32. Registrar's Signature <i>Jeanne B. Pollak</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
2007 04312
Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathryne Yvonne Hunt							2. Date of Death Month Day Year February 14, 2007	3. Time of Death 4:50 AM
	4a. Facility Name (If not institution, give street and number) Heritage Nursing Home				4b. City, Town, or Location of Death Dundalk			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 243-48-3742		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 20, 1936	9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent		10a. State Maryland 10b. County Baltimore			10c. City, Town or Location Rosedale			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 7881 Oakdale Avenue				10f. Zip Code 21237			10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year of Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Restaurant	
	17. Father's Name (First, Middle, Last) Henry Clay				18. Mother's Name (First, Middle, Maiden Surname) Ethel Elledge				
	19a. Informant's Name/Relationship (Type, Print) Teresa Ledwell - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 Rosewick Avenue Rosedale, Maryland 21237			Date	
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Holmefarm				20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens			20c. Location - City or Town, State 02/17/2007 Middle River, Maryland	
	21. Signature of Funeral Service Person Barbara J. Weber				22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE 15 YEARS							Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VASCULAR DEMENIA OLD CEREBROVASCULAR ACCIDENT								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D14160			29d. Date signed (Month, Day, Year) FEBRUARY 14, 2007			
	29b. Signature and title of certifier Harjot Singh MD								
	30. Name and address of person who completed chart of death (Item 23a) (Type) HARJIT SINGH MD #10-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND 21225								
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Leanne B. Aponte						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.									
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit document.									
Medical Certification: To Be Completed by Physician/Medical Examiner									
State Registrar									

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit document.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04313

1. For State
RegistrarPhysician/
Medical Examiner

Reg. No.

1. Decedent's Name (First, Middle, Last)

Mary Patricia Lampieri

2. Date of Death

Month

Day

Year

3 Time of Death
1610 hrsFuneral
Director

4a. Facility Name (if not institution, give street and number)

2 Kilglass Court #203

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore County

5. Social Security Number

212-44-0586

6. Sex

 M F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

02/16/1945

9. Birthplace (State or
Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

 Yes No

10e. Street and Number

2 Kilglass Court Apt. 203

10f. Zip Code

21093

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married2 Married3 Widowed4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes2 NoIf Yes, Give Year
Or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes2 No

specify:

14. Race - American Indian, Black,

White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done
during most of working life. DO NOT use retired)

12

Administrative Assistant

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Aloysius B. Pozaro

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Siford

19a. Informant's Name/Relationship (Type, Print)

Heather Maggio - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5900 Meadow Rose Elkridge, Maryland 21075

20a. Method of Disposition

1 Burial2 Cremation3 Removal from State20b. Place of Disposition (Name of cemetery,
crematory or other place)

Dulaney Valley

Memorial Gardens

Date

20c. Location - City or Town, State

02/16/2007 Timonium, Maryland

21. Signature of Funeral Service Licensee

David J. Weber

22. Name and Address of Facility

David J. Weber Funeral Homes P.A.

5311 Edmondson Avenue Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval
Between Onset and
DeathImmediate Cause (Final disease
or condition resulting in death)a. Bupropion intoxication

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

#23a,27,28a-f, perME, g865, 3/16/07 TT

IF FEMALE:

23b. Was decedent pregnant in the
past 12 months?1 Yes2 No9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Dither (Specify)9 Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes2 No3 Probably4 Unknown

24a. Was an autopsy performed?

1 Yes2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes2 No

25. Was case referred to medical examiner?

1 Yes2 NoHospital: 1 Inpatient2 ER/Outpatient3 DOA4 Nursing Home5 Residence6 Other Scene

26 Place of Death (Check only one)

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending
Investigation6 Could not be
determined

(Specify)

found at home

28a. Date of Injury
(Month, Day, Year)

Fnd 2/11/2007

Fnd 4:00 pm

28b. Time of Injury

1 Yes2 No

28c. Injury at Work?

subject ingested drug

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Kilglass Ct. #203

Timonium, MD

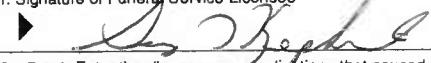
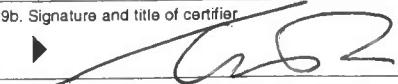
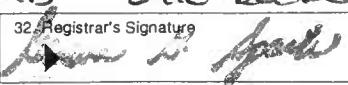
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04314

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rajagopala Subramanya Iyer							2. Date of Death Month Day Year February 12, 2007	3. Time of Death 8:23 PM M
	4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 218-23-4286	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) November 15, 1918	9. Birthplace (State or Foreign Country) India		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Bethesda 10e. Street and Number 5905 McKinley Street 10f. Zip Code 20817 10g. Citizen of What Country? India								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Asian Indian			14. Race - American Indian, Black, White, etc. Specify: Asian Indian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting		16b. Kind of Business/Industry Government of India				
	College (1-4 or 5+) 4								
	17. Father's Name (First, Middle, Last) P. Rajagopala Iyer			18. Mother's Name (First, Middle, Maiden Surname) G. Ammal Ammal					
	19a. Informant's Name/Relationship (Type, Print) Raja Iyer/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5905 McKinley Street Bethesda, Maryland 20817					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) M00335			20b. Place of Disposition (Name of cemetery, crematory or other place) MONTGOMERY Crematorium Inc.		Date February 15, 2007	20c. Location - City or Town, State Bethesda, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Failure Shock Liver Sick Sines Syndrome								
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
Medical Certification; To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier  MD								
	29c. License number DC1772								
	29d. Date signed (Month, Day, Year) 2/13/07								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tony Oae, MD 440 Rockledge Dr Suite 200 Bethesda MD								
	31. Date filed (Month, Day, Year) FEB 15 2007								
	32. Registrar's Signature 								

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036, Feb. 12, 2007 8:23PM

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23e or 28a show any injury or other traumatic event, it is Medical Examiner shall be notified at once.

State
Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #22, per FH, G864, 2/15/07 TT Register

Certificate of Death

Reg. No.

2007 04315

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA JENNINGS				2. Date of Death Month Day Year February 05 2007	3. Time of Death 0346 AM		
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death			
Funeral Director	5. Social Security Number 230-72-1713	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/30/1946	9. Birthplace (State or Foreign Country) VA	
	Usual Residence of Decedent 10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1018 North Payson Street				10f. Zip Code 21217		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: African American		14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry laundry worker		16c. Date of Death 02/10/2007		
17. Father's Name (First, Middle, Last) James E. Canada				18. Mother's Name (First, Middle, Maiden Surname) Virginia Jackson				
19a. Informant's Name/Relationship (Type, Print) Julia Jackson / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1018 North Payson Street; Baltimore, Maryland 21217				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mount Zion Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 02/10/2007	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee ►Teresa Jones			22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, MD 21217					
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. ATHEROSCLEROTIC CORONARY ARTERY DISEASE Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____				23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier ►Edward R. Flynn		29c. License number D31993		29d. Date signed (Month, Day, Year) FEB 12, 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARD BOLIANO MD 2000 W BALTIMORE ST 21223								
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Laura H. Smith						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

007 04316

Reg. No.

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Frank Jones

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Frank William Jones, Jr.		Feb. 10 2007				5:30 A M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Genesis Loch Raven Nursing Home		Baltimore				Baltimore	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) January 5, 1948	9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 124 West Franklin Street		10f. Zip Code 21201				10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3		16b. Kind of Business/Industry Sales Contractor			Credit Company
17. Father's Name (First, Middle, Last) Frank William Jones, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Lillian Baumgartner					
19a. Informant's Name/Relationship (Type, Print) Nicole Jones/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 W. Daming Pl. Apt. 109 Chicago, IL 60614					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Gifts Registry		Date February 10, 2007		20c. Location - City or Town, State Hanover, MD	
21. Signature of Funeral Service Licensee ► BO		22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P, Hanover, MD 21076					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Mult. p/c sclerosis							
Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of): Advanced Mult. p/c sclerosis</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier ► Dr. Attending Physician		29c. License number D5-3642				29d. Date signed (Month, Day, Year) Feb. 10 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIAO Zhou 6701 N. Charles ST 4202 Baltimore 21208							
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Jane S. Parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 317

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANKIE W. JOHNSON						2. Date of Death Month Day Year February 7 2007	3. Time of Death 2:40 p M
	4a. Facility Name (If not institution, give street and number) 404 DORSEY STREET			4b. City, Town, or Location of Death ABERDEEN			4c. County of Death HARFORD CO	
Funeral Director	5. Social Security Number 231-22-0434	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) MAR 30 1925	9. Birthplace (State or Foreign Country) MISSISSIPPI	
	Usual Residence of Decedent 10a. State MARYLAND			10b. County HARFORD CO			10c. City, Town or Location ABERDEEN	
10e. Street and Number 404 DORSEY STREET				10f. Zip Code 21001		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 9th grade		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry PRIVATE				
17. Father's Name (First, Middle, Last) JAMES A. WRIGHT				18. Mother's Name (First, Middle, Maiden Surname) FRANKIE CHEW				
19a. Informant's Name/Relationship (Type, Print) Frankie W. Johnson/Self				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Dorsey St., Aberdeen, Md., 21001				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BELAIR, MARYLAND		20b. Place of Disposition (Name of cemetery, crematory or other place) HARFORD MEMORIAL		Date 02-17-07		20c. Location - City or Town, State BELAIR, MARYLAND		
21. Signature of Funeral Service Licensee 								
22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) metastatic pancreatic Cancer Approximate Interval Between Onset and Death 6 months								
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 								
29c. License number D54841								
29d. Date signed (Month, Day, Year) 2/12/07								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ashkan Bahrani, M.D., 602 S. Atwood Rd., Suite 200 Belair, Md., 21014								
31. Date filed (Month, Day, Year) FEB 15 2007								
32. Registrar's Signature 								

ORIGINAL

Baltimore, Maryland 21215-0036
Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,
Physician /Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04318

1. For State Registrar

1. Decedent's Name (First, Middle, Last)

SAYAN SHA KELLEY, SR.

2. Date of Death

Month

Day

Year

February 5, 2007

3. Time of Death

0806 hrs

Physician/Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death			
SAYAN SHA KELLEY, SR.			Month February	Day 5	Year 2007	0806 hrs	
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
Southern Maryland Hospital			Clinton			Prince George's	
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)	
212-88-3326	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	32 Yrs.	Months	Days	Hours	Min.	MD
Usual Residence of Decedent							10d. Inside City Limits
10a. State	10b. County	10c. City, Town or Location					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
MD	PRINCE GEORGE'S	BELTSVILLE					
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
3316 DUNNINGTON RD.			20705			U.S.A.	
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry	
Elementary/Secondary (0-12)	College (1-4 or 5+)	LABORER			PRIVATE		
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
JAMES KELLEY				ROSETTA SETTLES			
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
DIANN SMITH/ SISTER			3339 SPOTTED FAWN DR. ORLANDO, FLORIDA 32817				
20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	GLENWOOD CEMETERY			2-12-2007	WASHINGTON, DC		
21. Signature of Funeral Service Licensee			22. Name and Address of Facility				
<i>BC Taylor</i>			TAYLOR'S FUNERAL HOME 1722 N. CAPITOL ST., NW WASH. DC 20001				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
a. <u>Atherosclerotic cardiovascular disease</u> Due to (or as a consequence of):							
b. _____ Due to (or as a consequence of):							
c. _____ Due to (or as a consequence of):							
d. _____							
<input type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED	#1,23a, PII, 27, per ME, g865, 3/30/07 TT					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy			23d. Date of delivery		
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth	2 <input type="checkbox"/> Fetal death	3 <input type="checkbox"/> Ectopic pregnancy	Date	Month	Day
		4 <input type="checkbox"/> Pregnant at time of death	5 <input type="checkbox"/> Other (Specify) _____	9 <input type="checkbox"/> Unknown	Year		
24. Did tobacco use contribute to the cause of death?							
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?					
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner?		26 Place of Death (Check only one)					
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:					
27. Manner of Death		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred		
1 <input checked="" type="checkbox"/> Natural 6 <input checked="" type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number					
		O.C.M.E.					
29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)					
<i>Pamela E. Southall, MD</i>		February 6, 2007					
30. Name and address of person who completed cause of death (Item 23a)		111 Penn Street, Baltimore, MD 21201					
Pamela E. Southall, MD Assistant Medical Examiner							
31. Date filed (Month, Day, Year)		32. Registrar's Signature					
FEB 15 2007		<i>[Signature]</i>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

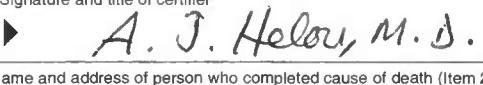
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04319

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Frederick Kleinsmith, Sr.							2. Date of Death Month Day Year FEBRUARY 12, 2007	3. Time of Death 07:15P M
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 219-16-5783	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 17, 1925	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland			10b. County Harford			10c. City, Town or Location Fallston		
10e. Street and Number 2403 StoneySide Drive				10f. Zip Code 21047-2807			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW 2		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1 USPS Clerk		16b. Kind of Business/Industry US Government					
17. Father's Name (First, Middle, Last) John Kleinsmith				18. Mother's Name (First, Middle, Maiden Surname) Isabelle Montgomery					
19a. Informant's Name/Relationship (Type, Print) Rose Marie Kleinsmith (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 StoneySide Drive, Fallston, Maryland 21047-2807					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory, Inc.			Date 2/15/07	20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCullly-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Balto., Md. 21230							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
<p>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
CARCINOMA OF THE LUNG								<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 		29c. License number D0017695			29d. Date signed (Month, Day, Year) February 13, 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. HELOU, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204								31. Date filed (Month, Day, Year) FEB 15 2007	
32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

EJ
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04320

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

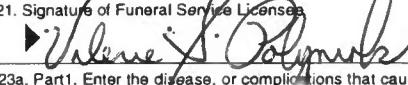
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
Margaret B. Kellenbenz		February 9, 2007				7:35 A.M.		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death		
842 Riverside Drive		Pasadena				Anne Arundel		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 8, 1911	9. Birthplace (State or Foreign Country) Maryland	
216-18-7833			95					
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Pasadena						
10e. Street and Number 2902 Dungate Road		10f. Zip Code 21122				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
Elementary/Secondary (0-12) 7		College (1-4 or 5+) N/A		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) William Shaffer				18. Mother's Name (First, Middle, Maiden Surname) Margaret Curran				
19a. Informant's Name/Relationship (Type, Print) Kenneth H. Kellenbenz (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 R Holloway Road Glen Burnie, Maryland 21060				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		Date	20c. Location - City or Town, State Elkridge Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCullly-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Approximate Interval Between Onset and Death dementia				
<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>pneumonia</i> <i>general debility</i>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) daughter's residence				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D448M				29d. Date signed (Month, Day, Year) 2-9-07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Karen M Dodge MD 8028 Kitchensburg suite 134 Pasadena MD 21122</i>								
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature <i>Dawn S. Gault</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 04321

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josephine Kania					2. Date of Death Month Day Year February 13, 2007	3. Time of Death 8:34 AM
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 114-46-6441	6. Sex 1 M 2 F	7. Age (In yrs, last birthday) 97 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 11, 1909	9. Birthplace (State or Foreign Country) New York	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Md. 10b. County N/A 10c. City, Town or Location Baltimore					10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 1 Ruxlea Ct.			10f. Zip Code 21204	10g. Citizen of What Country? USA		
Physician /Medical Examiner	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Joseph Podsiadlo	18. Mother's Name (First, Middle, Maiden Surname) Mrs. Lois Kakel		19a. Informant's Name/Relationship (Type, Print) daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Ruxlea Ct. Balt. Md. 21204	
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rood Cemetery		Date 2/17/2007	20c. Location - City or Town, State Westbury, New York		
	21. Signature of Funeral Service Licensee Jaysey Gray	22. Name and Address of Facility Joseph L. Russ Funeral Home, P.A. 2222 W. North Ave. Balt. Md. 21216					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death 3 days	
	a. Pulmonary Edema Due to (or as a consequence of):						
	b. Pneumonia Due to (or as a consequence of):					1 month	
	c. Due to (or as a consequence of):						
	d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
						24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	25. Was case referred to medical examiner? 1 Yes 2 No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)		
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier Danielle L. Brown, M.D.		29c. License number AT2438946		29d. Date signed (Month, Day, Year) February 13, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Danielle L. Brown, M.D. Union Memorial Hospital, MD						
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Danielle L. Brown				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 322

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICIA REGINA KEARNS					2. Date of Death Month Day Year February 13, 2007	3. Time of Death 7:30A M			
	4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 214-26-5075	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 21, 1927	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	10a. State Maryalnd 10b. County Baltimore 10c. City, Town or Location Baltimore						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No XX			
	10e. Street and Number 654 Regester Avenue			10f. Zip Code 21212		10g. Citizen of What Country? USA				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: XX		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Program Open Space Coordinator		16b. Kind of Business/Industry Baltimore County					
	17. Father's Name (First, Middle, Last) Thomas Alphonsus Kearns			18. Mother's Name (First, Middle, Maiden Surname) Margaret Marie Kelly						
	19a. Informant's Name/Relationship (Type, Print) Karole Keeney McElwee			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PR 20409 Keeney Mill Road Freeland Maryland 21053						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) XX			20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 2/17/07	20c. Location - City or Town, State Pikesville Maryland			
	21. Signature of Funeral Service Licensee Dennis Alphonse Keeney			22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke							Approximate Interval Between Onset and Death DMYS		
	b. Due to (or as a consequence of): Vascular Disease							Years		
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Patricia Regina Kearns MD		29c. License number D 58303		29d. Date signed (Month, Day, Year) February 13 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Regina Kearns MD 6701 N Charles St Baltimore MD 21204									
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Seal & Initials							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 04 323

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia Lee Kauffman						2. Date of Death Month February Day 13 Year 2007	3. Time of Death 10:52 A M		
	4a. Facility Name (If not institution, give street and number) LORIEN @ RIVERSIDE			4b. City, Town, or Location of Death Bekamp			4c. County of Death HARFORD			
Funeral Director	5. Social Security Number 219-56-4121		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) Nov. 11, 1950	9. Birthplace (State or Foreign Country) Washington, D.C.			
	10a. State Maryland		10b. County Harford	10c. City, Town or Location Joppa			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 122 Old Church Drive			10f. Zip Code 21085			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 4		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator		16b. Kind of Business/Industry Beauty Salon					
	17. Father's Name (First, Middle, Last) Richard Stanley Trimble			18. Mother's Name (First, Middle, Maiden Surname) Lottie Rae Houck						
	19a. Informant's Name/Relationship (Type, Print) Shawna Kauffman/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Old Church Drive, Joppa, Maryland 21085			Date 2-20-07	20c. Location - City or Town, State Bel Air, Maryland		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mt. Zion UMC Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion UMC Cemetery						
	21. Signature of Funeral Service Licensee R. M. N.Y.			22. Name and Address of Facility McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subarachnoid Hemorrhage due to Intracranial Aneurysm								Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of): Intracranial Aneurysm									
	c. Due to (or as a consequence of): 									
	d. Due to (or as a consequence of): 									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Necrotizing Pneumonia Failure to thrive								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 	
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 									
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29c. License number D19583	29d. Date signed (Month, Day, Year) February 13, 2007
	29b. Signature and title of certifier R. M. N.Y.								29c. License number D19583	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawna Kauffman								29d. Date signed (Month, Day, Year) February 13, 2007	
	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature R. M. N.Y.						

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04324

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James Joseph Kotmair</i>							2. Date of Death Month Day Year <i>February 10 2007</i>			3. Time of Death <i>9:05 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>1 Hamill Ct. Unit #21</i>			4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>				
Funeral Director	5. Social Security Number <i>215-42-9950</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>62 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <i>July 10, 1944</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>			
	10a. State <i>Maryland</i>		10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>1 Hamill Ct. Unit #21</i>			10f. Zip Code <i>21210</i>				10g. Citizen of What Country? <i>USA</i>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1967-1970</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Analyst</i>				16b. Kind of Business/Industry <i>DOD</i>				
	17. Father's Name (First, Middle, Last) <i>James Kotmair</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Catherine Doris Bauer</i>								
	19a. Informant's Name/Relationship (Type, Print) <i>Ann K. Kotmair / Spouse</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1 Hamill Ct. Unit #21 Baltimore, MD 21210</i>								
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>R&J</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Anatomy Gifts Registry</i>			Date <i>February 10, 2007</i>	20c. Location - City or Town, State <i>Hanover, MD</i>				
	21. Signature of Funeral Service Licensee <i>R&J</i>			22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P, Hanover, MD 21076								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <i>3 yrs</i>	
	<p>a. <i>amyotrophic lateral sclerosis</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <i>9</i>				23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>DOA</i>				28d. Describe how injury occurred				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <i>D 28030</i>						29d. Date signed (Month, Day, Year) <i>Feb 12, 2007</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DAVID R CORNWELL</i>			31. Date filed (Month, Day, Year) <i>FEB 15 2007</i>						32. Registrar's Signature <i>David R Cornwell</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04325

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Fred Laurence Kaiser	February 13, 2007	9:00 A M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2900 N. Leisure World Blvd., #207	Silver Spring	Montgomery

Funeral
Director

To Be Completed by Funeral Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
298-24-6885		77			August 24, 1929	Ohio
Usual Residence of Decedent		10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Maryland	Montgomery		Silver Spring			
10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?	
2900 North Leisure World Boulevard		20906			United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Driver Long Haul Trucking		
17. Father's Name (First, Middle, Last) Fred John Kaiser				18. Mother's Name (First, Middle, Maiden Surname) Frances Marian Grepps		
19a. Informant's Name/Relationship (Type, Print) Grace V. Kaiser / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 North Leisure World Boulevard, Silver Spring, Maryland 20906		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Northlawn Memorial Gardens		Date February 19, 2007	20c. Location - City or Town, State Peninsula, Ohio	
21. Signature of Funeral Service Licensee JM		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue/ Bethesda, Maryland 20814-3501				

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 6 months	
a. Due to (or as a consequence of): Pancreaticobiliary Carcinoma			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Type II Diabetes		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29b. Signature and title of certifier MD	29c. License number D43202	29d. Date signed (Month, Day, Year) February 13, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene O. Blankford, M.D. 3305 N. Leisure World Boulevard,		Silver Spring, Maryland 20906
31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature Linda B. Spaulding	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

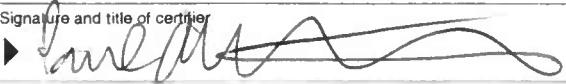
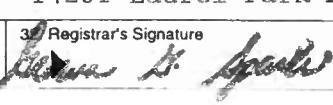
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04326

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard S. Kimmel				2. Date of Death Month February Day 10 , Year 2007	3. Time of Death 11:50 A M																	
	4a. Facility Name (If not institution, give street and number) 2842 Aquarius Avenue		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery																		
Funeral Director	5. Social Security Number 579-32-6758	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) December 6, 1928	9. Birthplace (State or Foreign Country) Washington D.C.																
	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																
10e. Street and Number 2842 Aquarius Avenue			10f. Zip Code 20906		10g. Citizen of What Country? United States																		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Document Specialist			16b. Kind of Business/Industry Federal Government																	
17. Father's Name (First, Middle, Last) Earl Kimmel				18. Mother's Name (First, Middle, Maiden Surname) Ida Simpson																			
19a. Informant's Name/Relationship (Type, Print) Lynn K. Cherrier/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Mansfield Street, Chippewa Falls, WI 54729																			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) M01433		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date February 12, 2007	20c. Location - City or Town, State Bethesda, Maryland																		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850																					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																							
<table border="0"> <tr> <td>a. Coronary Artery Disease Due to (or as a consequence of):</td> <td colspan="3">Approximate Interval Between Onset and Death 20 Years</td> </tr> <tr> <td>b. Ischemic Cardiomyopathy Due to (or as a consequence of):</td> <td colspan="3">10 Years</td> </tr> <tr> <td>c. Type II Diabetes Due to (or as a consequence of):</td> <td colspan="3">20 Years</td> </tr> <tr> <td>d. Hypertension</td> <td colspan="3">20 Years</td> </tr> </table>								a. Coronary Artery Disease Due to (or as a consequence of):	Approximate Interval Between Onset and Death 20 Years			b. Ischemic Cardiomyopathy Due to (or as a consequence of):	10 Years			c. Type II Diabetes Due to (or as a consequence of):	20 Years			d. Hypertension	20 Years		
a. Coronary Artery Disease Due to (or as a consequence of):	Approximate Interval Between Onset and Death 20 Years																						
b. Ischemic Cardiomyopathy Due to (or as a consequence of):	10 Years																						
c. Type II Diabetes Due to (or as a consequence of):	20 Years																						
d. Hypertension	20 Years																						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease																							
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred																		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D43237																					
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) February 12, 2007																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, M.D. 14201 Laurel Park Drive, Suite 102, Laurel, Maryland 20707																							
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 																					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or Item 23a or 28-1 show any injury or other traumatic event, the Medical Examiner must be notified at all times.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, W.B.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 04327

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah Northington Lucas					2. Date of Death Month Day Year 02/10/2007	3. Time of Death 7:45 p M	
	4a. Facility Name (If not institution, give street and number) 8600 Roaming Ridge Way # 104			4b. City, Town, or Location of Death Odenton		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 579-10-8022	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/04/1916	9. Birthplace (State or Foreign Country) LaCrosse, VA	
To Be Completed by Funeral Director	10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Odenton						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8600 Roaming Ridge Way # 104			10f. Zip Code Odenton		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative			16b. Kind of Business/Industry Government	
	17. Father's Name (First, Middle, Last) Samuel Northington			18. Mother's Name (First, Middle, Maiden Surname) Maggie Lester				
	19a. Informant's Name/Relationship (Type, Print) Toni Killings / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 Roaming Ridge Way#104 Odenton, MD 21113				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.	Date 02/20/07	20c. Location - City or Town, State Clinton, Maryland		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Taylor's Funeral Home 1722 N. Capitol St. NW Washington, DC 20002				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Atherosclerotic Cerebrovascular disease b. Due to (or as a consequence of): Hypertension c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 			29c. License number H45839		29d. Date signed (Month, Day, Year) 2/15/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5511 West Cedar Lane Bethesda, md 20814							
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or Items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

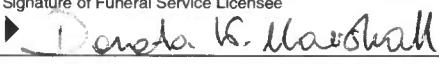
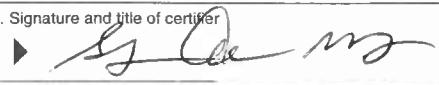
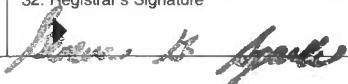
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04328

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernice Josephine Lent					2. Date of Death Month Day Year February 12, 2007	3. Time of Death 3:41pM	
	4a. Facility Name (If not institution, give street and number) 10201 Wesleigh Drive			4b. City, Town, or Location of Death Columbia		4c. County of Death Howard		
Funeral Director	5. Social Security Number 354-14-7339	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months 88	If Under 24 Hrs. Days 0	8. Date of Birth Month Day Year 3/10/1918	9. Birthplace (State or Foreign Country) IL	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State WI 10b. County Kenosha 10c. City, Town or Location Twin Lakes					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1137 Legion Drive			10f. Zip Code 53181		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Elementary School			
	17. Father's Name (First, Middle, Last) Mathias Nimsgerm				18. Mother's Name (First, Middle, Maiden Surname) Mary Pittges			
	19a. Informant's Name/Relationship (Type, Print) Linda Lent / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Freeman Street, Genoa City, WI 53128				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bloesemburg		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 2/17/2007	20c. Location - City or Town, State Fish Creek, WI		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore MD 21230					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End stage congestive heart failure Approximate Interval Between Onset and Death							
	b. Due to (or as a consequence of): Hypertension							
	c. Due to (or as a consequence of): Tuberculosis							
	d. Due to (or as a consequence of): Coronary artery disease							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9		23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) daughter's residence					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D50870		29d. Date signed (Month, Day, Year) February 13th 2007			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzan Ando 5005 Signal Bell Lane Clarksville MD 21029							
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

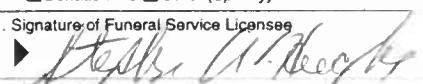
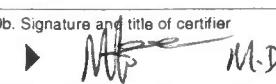
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 329

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year	3. Time of Death
	Frederick Albert Lyons					February 7, 2007	4:00 P M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death
	136 Lariat Road			Middle River			Baltimore
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213-28-7056 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F 76 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.							
8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Sept. 7, 1930 Maryland							
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore							
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 Lariat Road 21220 USA							
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced If Yes, Give Year or Dates: Korea			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			14. Race - American Indian, Black, White, etc. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Mechanic Specify: White		
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jess Albert Lyons Elizabeth (nmn) Porter							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			19c. Date		
Freda Lyons/Wife		136 Lariat Road, Baltimore, Maryland 21220			20c. Location - City or Town, State Joppa, Maryland		
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Date		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Trinity Lutheran Cem. 2-14-07			20c. Location - City or Town, State Joppa, Maryland		
21. Signature of Funeral Service Licensee 							
22. Name and Address of Facility McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009							
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Suspected Arrhythmias Approximate Interval Between Onset and Death 1-2 hrs							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): I O chronic Cardiomyopathy b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe COPD, Sleep apnea. CKD							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D-38754			29d. Date signed (Month, Day, Year) 02-08-2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAUKA WASERM, 709 EASTERN BLVD. M-D - 21221							
31. Date filed (Month, Day, Year)		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04330

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, F.C.U.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)	CHARLES LEWIS, JR.	2. Date of Death Month Day Year	3. Time of Death
Funeral Director	4a. Facility Name (If not institution, give street and number)	CARROLL HOSPITAL CENTER	4b. City, Town, or Location of Death	WESTMINSTER
	4c. County of Death	CARROLL	4d. Date of Birth (Month, Day, Year)	7/17/1919
	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	8. Birthplace (State or Foreign Country) ILLINOIS
	9. If Under 1 Year Months Days	10. If Under 24 Hrs. Hours Min.	11. 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10a. State MD	10b. County CARROLL	10c. City, Town or Location WESTMINSTER	
	10e. Street and Number 130 HAHN RD.	10f. Zip Code 21157	10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1	16b. Kind of Business/Industry MANAGER	
	17. Father's Name (First, Middle, Last) CHARLES B. LEWIS, SR.	18. Mother's Name (First, Middle, Maiden Surname) BESSIE DUSTIN		
	19a. Informant's Name/Relationship (Type, Print) JENNIE S. LEWIS - WIFE	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 HAHN RD., WESTMINSTER, MD 21157		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) EVERGREEN CEMETERY	Date 2/12/07	20c. Location - City or Town, State GETTYSBURG, PA
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 20 days		
	a. Due to (or as a consequence of): Pneumonia			
	b. Due to (or as a consequence of):			
	c. Due to (or as a consequence of):			
	d. Due to (or as a consequence of):			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number 100059943	29d. Date signed (Month, Day, Year) February 9, 2007	
	29b. Signature and title of certifier 	29c. License number 100059943	29d. Date signed (Month, Day, Year) February 9, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Adams 295 Spur Av Suite 307 Westminster MD 21157			
	31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature 		

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

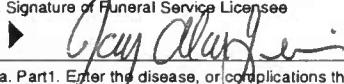
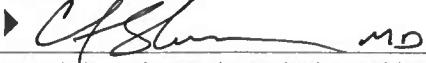
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04331

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ISAAC LEVYS							2. Date of Death Month Day Year February 10 2007	3. Time of Death 11:31 PM	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore			4b. City, Town, or Location of Death Baltimore City			4c. County of Death N/A			
Funeral Director	5. Social Security Number 125-22-4579	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 04/15/1911	9. Birthplace (State or Foreign Country) ISRAEL			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location BALTIMORE								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 3801 CANTERBURY ROAD #401				10f. Zip Code 21218			10g. Citizen of What Country? USA		
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER			16b. Kind of Business/Industry LEVEL EXPORT			
Baltimore, Maryland 21215-0036	17. Father's Name (First, Middle, Last) ABRAHAM				18. Mother's Name (First, Middle, Maiden Surname) SULTANA ELYACHAR					
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	19a. Informant's Name/Relationship (Type, Print) ANDREE LEVYS / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 CANTERBURY ROAD #401 - BALTIMORE, MD 21218					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMINU		Date 2/12/2007	20c. Location - City or Town, State BALTIMORE, MD				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death 2 days	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Myocardial infarction									
	b. Due to (or as a consequence of): Coronary Artery Disease (Atherosclerosis)									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Insufficiency Ischemic colitis								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  Carl F. Sloan, MD						29c. License number R ES - 000	29d. Date signed (Month, Day, Year) February 10, 2007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl F. Sloan, MD Sinai Hospital of Baltimore		31. Date filed (Month, Day, Year) FEB 15 2007						32. Registrar's Signature 	

REPLACEMENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #21, per FD, 0866, 4/16/07 II
Registrar

Certificate of Death

Reg. No.

2007-04332

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TYRONE MCNAIR, SR.							2. Date of Death Month Day Year Feb. 9, 2007	3. Time of Death 0735 hrs. M
	4a. Facility Name (If not institution, give street and number) 3105 Mareco Avenue				4b. City, Town, or Location of Death Baltimore			4c. County of Death	
Funeral Director	5. Social Security Number 220-78-4245	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8/8/1960	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD		10b. County Baltimore	10c. City, Town or Location Essex			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1323 Maple Avenue			10f. Zip Code 21221			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: USMC		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Technician			16b. Kind of Business/Industry Electrical			
	17. Father's Name (First, Middle, Last) Sedberry McNair				18. Mother's Name (First, Middle, Maiden Surname) Ollie McCuin				
	19a. Informant's Name/Relationship (Type. Print) Ollie McNair / Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1323 Maple Avenue, Essex, MD 21221					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery Garrison Forest			Date 2/20/2007	20c. Location - City or Town, State Owings Mills, MD	
	21. Signature of Funeral Service Licensee Dwayne A. Lowry, per DVR				22. Name and Address of Facility Howell Funeral Home 4600 Liberty Heights Ave. Baltimore, MD 21207				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	a. Acute ethanol intoxication Due to (or as a consequence of): b. _____ c. _____ d. _____								
	Approximate Interval Between Onset and Death								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Morphine use								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene								
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) Fnd 2/9/2007								
	28b. Time of Injury Fnd 7:30 AM								
	28c. Injury at Work? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No unknown								
	28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) found in house								
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3105 Mareco Ave. Baltimore, MD								
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Patricia Aronica-Pollak, MD								
	29c. License number O.C.M.E.								
	29d. Date signed (Month, Day, Year) Feb. 10, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
	31. Date filed (Month, Day, Year) APR 19 2007								
	32. Registrar's Signature Renee B. Spangler								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

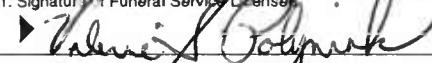
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 333

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bettie A. McRobie							2. Date of Death Month Day Year February 12, 2007	3. Time of Death 1:10 p m		
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare			4b. City, Town, or Location of Death Severna Park			4c. County of Death Anne Arundel				
Funeral Director	5. Social Security Number 221-18-9008		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 20, 1929			9. Birthplace (State or Foreign Country) Delaware		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Pasadena									10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8243 Forest Glen Drive				10f. Zip Code 21122			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Toll Sergeant		16b. Kind of Business/Industry Bay Bridge						
	17. Father's Name (First, Middle, Last) Benjamin B. Marvel		18. Mother's Name (First, Middle, Maiden Surname) Katherine Spear								
	19a. Informant's Name/Relationship (Type, Print) Robert S. McRobie (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8420 Alvin Road, Pasadena, Maryland 21122								
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Pk.		Date 02/16/2007			20c. Location - City or Town, State Elkridge, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCullly-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DIS		Approximate Interval Between Onset and Death YEARS						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D31136		29d. Date signed (Month, Day, Year) FEBRUARY 14, 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian C. Wallace MD, 9005 Kildridge Rd, Baltimore, MD 21236										
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be informed.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04334

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elsie M. Mann							2. Date of Death Month February Day 13 , Year 2007	3. Time of Death 12:57 PM	
	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll			
Funeral Director	5. Social Security Number 214 30 2059	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) OCT 13 1913	9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent 10a. State MD 10b. County CARROLL 10c. City, Town or Location WESTMINSTER			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
To Be Completed by Funeral Director	10e. Street and Number 4115 RINGE ROAD			10f. Zip Code 21157			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) LEE WARD				18. Mother's Name (First, Middle, Maiden Surname) ELSIE BARNES					
	19a. Informant's Name/Relationship (Type, Print) NANCY SMITH /DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2570 DEER PARK ROAD FINKSBURG MD 21048-2214						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) PROVIDENCE CEM.			Date 2/16/2007	20c. Location - City or Town, State FINKSBURG, MD		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Jeff N. Zumbur			22. Name and Address of Facility JNZUMBUR FTF & SON CO 6028 SYKEVILLE ROAD ELKERSBURG MD 21784						
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death hours	
	<p>a. Due to (or as a consequence of): Myocardial Infarction</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number 00059943						
	29b. Signature and title of certifier John A. Adams			29d. Date signed (Month, Day, Year) January 13, 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John A. Adams 215 Spur Ave. Suite 307 Westminster MD 21157									
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature John A. Adams						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

1- For
State
Registrar

2007 04335
Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

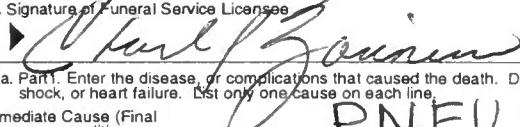
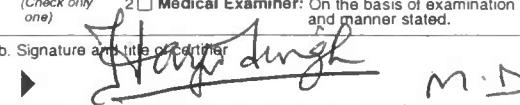
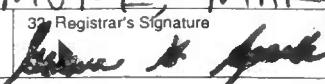
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

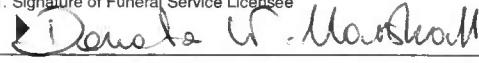
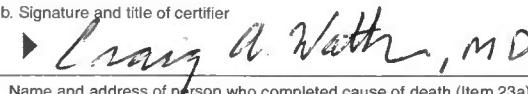
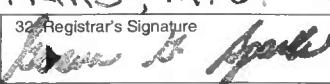
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year		3. Time of Death P.M.
Ella Machlinski			Feb. 14, 2007		12:00 P.M.
4a. Facility Name (If not institution, give street and number) Heritage Center at Genesis			4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore
5. Social Security Number 212-09-6864		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 3-16-1918
10a. State Maryland			10c. City, Town or Location Dundalk		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 7232 German Hill Road			10f. Zip Code 21222		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home
17. Father's Name (First, Middle, Last) Tony Rossi			18. Mother's Name (First, Middle, Maiden Surname) Filomena Giannino		
19a. Informant's Name/Relationship (Type, Print) Stephen F. Machlinski-Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8366 Poplar Mill Rd. White Marsh, Md. 21236		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus		Date Feb 17, 07	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 21224 263 S. Conkling St.		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Approximate Interval Between Onset and Death 10 DAYS.		
<p>a. _____ Due to (or as a consequence of): PNEUMONIA</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS HYPERTENSION					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 14160		29d. Date signed (Month, Day, Year) FEBRUARY 14, 2007	
29b. Signature and title of certifier 					
30. Name and address of person who completed cause of death (Item 2a) (Type, Print) HARRY SINGH M.D. 5410-A RITCHIE HIGHWAY BALTIMORE, MARYLAND - 21225		31. Date filed (Month, Day, Year) FEB 15 2007			
		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 Per Phy & 12, 17 & 20B Per MD 8865 3/07/07 JH
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death
 Reg. No. 2007 04336

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Momeski Robert L. Momesky							2. Date of Death Month Day Year February 9, 2007	3. Time of Death 06:15 PM
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore City			4c. County of Death	
Funeral Director	5. Social Security Number 521-32-5409	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 30, 1931	9. Birthplace (State or Foreign Country) CO		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD				10b. County 10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 3501 Saint Paul Street, Apartment 212				10f. Zip Code 21218			10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1954-56 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean War			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Railroad	
	17. Father's Name (First, Middle, Last) Joseph F. Momeski Momesky				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth P. Kratky				
	19a. Informant's Name/Relationship (Type, Print) Mary Warner / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7780 West 64th. Avenue, Arvada, CO 80004				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Logan National Cemetery			20c. Location - City or Town, State Denver, CO	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death 2 years				
	a. Due to (or as a consequence of): Non Small Cell Carcinoma of Lung								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
					28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
					28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			29c. License number BW 9741871	29d. Date signed (Month, Day, Year) 2-9-07
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig A. Watkins, M.D. UNION MEMORIAL HOSPITAL, MD								
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #10e, per FH, g864, 2/15/07 TT Certificate of Death

Reg. No. 2007 04337

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Mae Mason					2. Date of Death Month 02 Day 12 Year 2007	3. Time of Death 3:40 A M		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death			
Funeral Director	5. Social Security Number 215-28-3503	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08/01/1932	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State MD			10b. County			10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 3829 Roland View Avenue			10f. Zip Code 21215		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify African American			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry homemaker		16c. Kind of Business/Industry domestic			
	17. Father's Name (First, Middle, Last) Henry Frazier			18. Mother's Name (First, Middle, Maiden Surname) Helen Crampton					
	19a. Informant's Name/Relationship (Type, Print) Dana Powell / Granddaughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3053 Brighton Street; Baltimore, Maryland 21216					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 02/13/2007	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee <i>Jessica Jones</i>			22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	<p>a. <i>Diabetic Mellitus</i> Due to (or as a consequence of):</p> <p>b. <i>Diabetic Nephropathy</i> Due to (or as a consequence of):</p> <p>c. <i>Hypertension</i> Due to (or as a consequence of):</p> <p>d. <i>Congestive Heart Failure</i></p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>peripheral vascular disease</i> <i>coronary artery disease</i>								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Wylie B. MVELBA, MD</i>			29c. License number 55425			29d. Date signed (Month, Day, Year) 2/12/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Wylie B. MVELBA, MD 413 Commonwealth AV, Catonsville, MD 21228</i>								
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature <i>Susan B. Jones</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 338

1- For State Registrar

Reg. No.

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last)

Paul McAllister

2. Date of Death

Month Day Year

3. Time of Death

0957 hrs

4a. Facility Name (if not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

220-90-6251

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

39

Yrs.

If Under 1 Year
Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

05/16/1967

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits
1 Yes 2 No

10e. Street and Number

2013 East Oliver Street

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married2 Married3 Widowed4 Divorced12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No specify:

14. Race - American Indian, Black, White, etc.

African
Specify: American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

machine operator

16b. Kind of Business/Industry

Good Wrappers

17. Father's Name (First, Middle, Last)

Paul D. McAllister

18. Mother's Name (First, Middle, Maiden Surname)

Grace Reilly

19a. Informant's Name/Relationship (Type, Print)

Sean Williams / Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2013 East Oliver Street; Baltimore, Maryland 21213

20a. Method of Disposition

1 Burial2 Cremation3 Removal from State4 Donation5 Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Zion Cemetery

Date

02/17/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Suzela Jones

22. Name and Address of Facility

Wylie Funeral Home, P.A.

638 North Gilmor Street; Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Drowning and hypothermia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

#23a,27,28a-f, per ME, g864, 2/26/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes2 No9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)9 Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes2 NoHospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther: 4 Nursing Home 5 Residence 6 Other

26 Place of Death (Check only one)

27. Manner of Death

1 Natural5 Pending Investigation2 Accident3 Suicide4 Homicide

28a. Date of Injury (Month, Day, Year)

2/7/2007

28b. Time of Injury

End 2:30 am

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Harbor (pier 5)

28d. Describe how, injury occurred

Subject slipped from pier into water

28f. Location (Street and Number or Rural Route Number, City or Town, State)

700 blk. Eastern Ave. Baltimore, MD

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Laron Locke MD.

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 8, 2007

31. Date filed (Month, Day, Year)

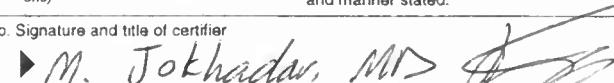
FEB 15 2007

32. Registrar's Signature

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
1- For Amend #23a PI, per MD , g864, 2/15/07 TT Certificate of Death Reg. No. 2007 04339

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Mae Mollica							2. Date of Death Month Day Year February 6, 2007	3. Time of Death 7:50 PM
	4a. Facility Name (If not institution, give street and number) Calvert Manor Nursing Home							4b. City, Town, or Location of Death Rising Sun	4c. County of Death Cecil
Funeral Director	5. Social Security Number 231-24-6869		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 1, 1926	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent 10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1509 Southview Road				10f. Zip Code 21015		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Provisioning Assistant		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Thomas Andrew Bratton			18. Mother's Name (First, Middle, Maiden Surname) Maude Elizabeth Hutchison					
	19a. Informant's Name/Relationship (Type, Print) Betty A. Wagner / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Gregory Drive, Forest Hill, Maryland 21050					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bel Air Memorial Gardens			20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens		Date 2-10-07	20c. Location - City or Town, State Bel Air, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration Pneumonia								Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): Failure to Thrive								
	b. Due to (or as a consequence of): End stage dementia								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	29b. Signature and title of certifier 			29c. License number D60768		29d. Date signed (Month, Day, Year) 2/17/07			
	30. Name and address of person who completed cause of death (Item 2a) (Type, Print) M. Jokhadar			31. Date filed (Month, Day, Year) FEB 15 2007					
	32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner (or the Medical Examiner if not the funeral director) must be notified at once.

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04340
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Alfred McDonald							2. Date of Death Month Day Year February 9, 2007	3. Time of Death M 6:10 P M
	4a. Facility Name (If not institution, give street and number) 3020 Fallston Rd.			4b. City, Town, or Location of Death Fallston			4c. County of Death Harford		
Funeral Director	5. Social Security Number 237-32-7221	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Mar. 5, 1924	9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent Maryland Harford			10c. City, Town or Location Fallston			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 3020 Fallston Road			10f. Zip Code 21047			10g. Citizen of What Country? USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager Quality Control Dept. Energy Systems			16b. Kind of Business/Industry				
	College (1-4 or 5+) 5+								
	17. Father's Name (First, Middle, Last) William Thomas McDonald	18. Mother's Name (First, Middle, Maiden Surname) Willie Jane Rush							
	19a. Informant's Name/Relationship (Type, Print) Marilyn R. McDonald / Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3020 Fallston Rd., Fallston, Maryland 21047			Date			20c. Location - City or Town, State Joppa, Maryland	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Mountain Christian			20c. Name and Address of Facility McComas Funeral Home, P.A.				
								1317 Cokesbury Road, Abingdon, Maryland 21009	
	21. Signature of Funeral Service Licensee <i>Marilyn R. McDonald</i>	22. Approximate Interval Between Onset and Death							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Due to (or as a consequence of): CARDIOMYOPATHY			23c. Due to (or as a consequence of): ISCHEMIC HEART DISEASE				
	a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	23d. Date of delivery Month Day Year							
	b.								
	c.								
	d.								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Tim Herlihy, MD</i>			29c. License number D 32639			29d. Date signed (Month, Day, Year) 2/12/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIM HERLIHY, MD 120 SISTER PARK DR. #204 TOWSON MD 21204								
	31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature <i>Please be seated</i>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04341

1- For State Registrar

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year February 5, 2007	3. Time of Death 1658 hrs
JUANDRE TYRONE MIMS		

4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death Baltimore	
5. Social Security Number 219-78-3204	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY) FEB. 22, 1962	9. Birthplace (State or Foreign Country) Maryland		
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

10e. Street and Number 4107 KATHLAND Ave	10f. Zip Code 21207	10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th grade	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Carpenter	16b. Kind of Business/Industry Self Employed
--	---	---

17. Father's Name (First, Middle, Last) Douglas Mims	18. Mother's Name (First, Middle, Maiden Surname) Juanita Crossen
---	--

19a. Informant's Name/Relationship (Type, Print) Junnita Mims / MOTHER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 KATHLAND Ave Baltimore, MD 21207
---	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery	Date 2/10/07	20c. Location - City or Town, State Woodlawn, Maryland
---	---	-----------------	---

21. Signature of Funeral Service Licensee Suey Juan	22. Name and Address of Facility CHATHAM HOMES NURSING HOME 5240 REISTERSTOWN ROAD BALTIMORE, MARYLAND
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Narcotic and alcohol intoxication Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED #1.23a, 27, 28a-f, per ME, g865 3/16/07 TT	
--	---	--

IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
------------	---	---

23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other	26. Place of Death (Check only one)
---	---	-------------------------------------

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Feb 2/5/2007	28b. Time of Injury Feb 3:54 pm	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unk
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) house			28f. Location (Street and Number or Rural Route Number, City or Town, State) 4103 Fairfax Ave. Baltimore, MD

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier Pamela E. Southall, MD	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 6, 2007
--	---	---------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
--

31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature John J. Smith
--	--

ORIGINAL

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04342

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John Joseph Michaels</i>					2. Date of Death Month Feb Day 11 Year 2007		3. Time of Death 17:08 M	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>					4b. City, Town, or Location of Death <i>Baltimore, MD</i>		4c. County of Death	
Funeral Director	5. Social Security Number <i>161-26-9627</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>73 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>Nov. 27, 1933</i>	9. Birthplace (State or Foreign Country) <i>PA</i>		
	Usual Residence of Decedent 10a. State <i>MD</i>		10b. County <i>Anne Arundel</i>	10c. City, Town or Location <i>Glen Burnie</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <i>111 Hollywood Drive</i>			10f. Zip Code <i>21060</i>			10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1950</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Maintenance Mechanic</i>		16b. Kind of Business/Industry <i>Chemical Company</i>				
	17. Father's Name (First, Middle, Last) <i>John Michaels</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Mihely</i>					
	19a. Informant's Name/Relationship (Type. Print) <i>Mrs. Lucille Michaels/Wife</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>111 Hollywood Drive Glen Burnie, MD 21060</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Chesapeake Cremation</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Chesapeake Cremation</i>		Date <i>Feb. 17, 2007</i>	20c. Location - City or Town, State <i>Stevensville, MD</i>			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061</i>						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Plenral effusion</i>			Approximate Interval Between Onset and Death <i>24 hrs.</i>					
	a. Due to (or as a consequence of): <i>Plenral effusion</i>								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension Type II Diabetes Obstructive Sleep Apnea</i>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29d. Date signed (Month, Day, Year) <i>February, 11, 2007</i>					
	29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <i>D0060563</i>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE / Pulmonary Division / MSTF 800 605 West Baltimore Street, BALTIMORE, MD 21201</i>								
State Registrar	31. Date filed (Month, Day, Year) <i>FEB 15 2007</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04343

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP, G., OSBORNE					2. Date of Death Month Day Year FEBRUARY 11 2007	3. Time of Death 00:15 AM
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER					4b. City, Town, or Location of Death BALTIMORE	4c. County of Death Ohio
Funeral Director	5. Social Security Number 213-34-8092	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) Nov 10, 1936	9. Birthplace (State or Foreign Country) Ohio	
To Be Completed by Funeral Director	10a. State Md. 10b. County 10c. City, Town or Location Baltimore					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 3213 Esther Place			10f. Zip Code 21224	10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Auto Body Man	16b. Kind of Business/Industry Auto Repair Shop			
	17. Father's Name (First, Middle, Last) Clarence Lee Osborne			18. Mother's Name (First, Middle, Maiden Surname) Jessie T. Moore			
	19a. Informant's Name/Relationship (Type, Print) Frances Osborne (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Esther Place Baltimore, Maryland 21224				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Robert J. Sodack		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory	Date 2-13-07	20c. Location - City or Town, State Baltimore, Maryland		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee ► Robert J. Sodack		22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Maryland 21222				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	<p>a. RESPIRATORY FAILURE Due to (or as a consequence of):</p> <p>b. CORONARY ARTERY Disease Due to (or as a consequence of):</p> <p>c. Diabetes Due to (or as a consequence of):</p> <p>d. _____</p>						
	<p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____</p> <p>23d. Date of delivery Month Day Year</p>						
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Stroke</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p>						
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____</p> <p>26. Place of Death (Check only one)</p>						
	<p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p>						
	<p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>						
	<p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier ► Robert J. Sodack</p> <p>29c. License number RES - 000</p> <p>29d. Date signed (Month, Day, Year) FEBRUARY 11, 2007</p>						
	<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diego Belandi M.D. 4940 EASTERN AVENUE BALTIMORE MD 21224</p>						
State Registrar	31. Date filed (Month, Day, Year) FEB 14 2007	32. Registrar's Signature Robert J. Sodack					

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04344

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ANNE H. PHELPS	Feb. 09, 2007	6:40 p M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Nursing Home	Timonium	Baltimore

Funeral
Director

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 27, 1923	9. Birthplace (State or Foreign Country) Maryland
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To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

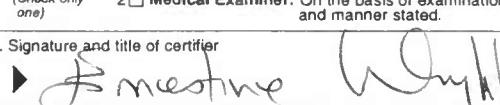
Baltimore, Maryland 21215-0036

6:40 P.M.

ANNE PHELPS FEBRUARY 9, 2007
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Towson	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 28 Dunvale Road Apt. B		10f. Zip Code 21204	10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0	16b. Kind of Business/Industry Caseworker	State of Maryland
17. Father's Name (First, Middle, Last) John M. Smith	18. Mother's Name (First, Middle, Maiden Surname) Victoria R. Sanford	19a. Informant's Name/Relationship (Type, Print) Kenneth O. Phelps Sr. (Husband)	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Dunvale Road, Apt. B, Towson, Maryland 21204		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park
		Date 02-13-07	20c. Location - City or Town, State Glen Burnie, Maryland
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death months		
a. Haemorrhagic Stroke Due to (or as a consequence of):			
b. Chronic Atrial Fibrillation Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29d. Date signed (Month, Day, Year) February 12th 2007		
29b. Signature and title of certifier 	29c. License number DS2740		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093	31. Date filed (Month, Day, Year) FEB 15 2007		
32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04345

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

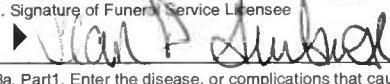
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 2a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 82

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Nancy L. Pinkerton				2. Date of Death Month Day Year February 10, 2007	3. Time of Death 5:35 A M
4a. Facility Name (If not institution, give street and number) 4508 Maple Ave				4b. City, Town, or Location of Death Halethorpe	
5. Social Security Number 212-42-5020				6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.
				If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
				8. Date of Birth (Month, Day, Year) 02/16/1944	
				9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MD	10b. County Baltimore	10c. City, Town or Location Halethorpe			
10e. Street and Number 4508 Maple Ave				10f. Zip Code 21227	10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 4+		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Agent		16b. Kind of Business/Industry Insurance	
17. Father's Name (First, Middle, Last) Louis J. Andrews				18. Mother's Name (First, Middle, Maiden Surname) Ann M. Poehlmann	
19a. Informant's Name/Relationship (Type, Print) John E. Pinkerton, Jr. / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4508 Maple Ave Halethorpe, Maryland 21227	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Loudon Park Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 02/11/2007	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Arbutus, Maryland 21227	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cervical cancer					
Approximate Interval Between Onset and Death 6 MONTHS					
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D53590			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) February 10, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYDNEY M. DY, MD		Room 609, 624 N BROADWAY BALTIMORE MD 21205			
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 			

ORIGINAL

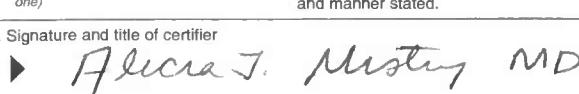
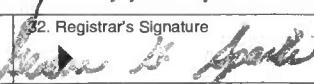
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04346

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Micheline E. Pelletier							2. Date of Death Month Day Year February 7, 2007	3. Time of Death 1710 M	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 104-24-8606	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 19, 1922	9. Birthplace (State or Foreign Country) France			
	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery				10c. City, Town or Location Rockville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 14431 Traville Garden Circle, #306D				10f. Zip Code 20850		10g. Citizen of What Country? United States			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Self-Employed		16b. Kind of Business/Industry Seamstress					
	17. Father's Name (First, Middle, Last) Paul Lapointe				18. Mother's Name (First, Middle, Maiden Surname) Georgette Mouilleron					
	19a. Informant's Name/Relationship (Type, Print) Denise M. Morrow/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Kent Gardens Circle, Gaithersburg, Maryland 20878						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date February 11, 2007	20c. Location - City or Town, State Bethesda, Maryland				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue M00803 Rockville, Maryland 20850-2805							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number D59738		29d. Date signed (Month, Day, Year) February 8, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alicia T. Misty 9901 Medical Center Drive Rockville, MD 20850									
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, E-

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #17,18, per FH, G864, 2/15/07 To Certificate of Death

Reg. No. 2007 04347

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORIS KAPP					2. Date of Death Month 2 Day 11 Year 2007	3. Time of Death 1800 M						
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A					
Funeral Director	5. Social Security Number 219-16-9445	6. Sex 1 □ M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth Month July Day 13 Year 1924	9. Birthplace (State or Foreign Maryland)						
	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel					10c. City, Town or Location Pasadena		10d. Inside City Limits 1 □ Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 7858 Mayford Avenue			10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.							
	11. Marital Status 1 □ Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cake Decorator			16b. Kind of Business/Industry Bakery						
	17. Father's Name (First, Middle, Last) Unknown Phillip J.			18. Mother's Name (First, Middle, Maiden Surname) Bertha Unknown M. Johnson									
	19a. Informant's Name/Relationship (Type, Print) Linda May Benson (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7858 Mayford Avenue, Pasadena, Maryland 21122									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville VA Cem.		Date 02-15-07	20c. Location - City or Town, State Crownsville, Maryland							
	21. Signature of Funeral Service Licensee Yolanda M. Lenz		22. Name and Address of Facility McCullly-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122										
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction							Approximate Interval Between Onset and Death					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease												
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Aortic Stenosis							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 <input checked="" type="checkbox"/> Probably 4 □ Unknown					
	MITRAL REGURGITATION Multi Organ Failure							24a. Was an autopsy performed? 1 □ Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 □ Yes 2 <input checked="" type="checkbox"/> No		Hospital: Inpatient		26. Place of Death (Check only one) 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		28c. Injury at Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred						
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	29b. Signature and title of certifier Yolanda M. Lenz							29c. License number F21207	29d. Date signed (Month, Day, Year) 2/11/2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOLANDA M. LENZ M.D 22 S. GREENE ST. BALTIMORE, MD 21201												
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Yolanda M. Lenz		ORIGINAL								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, E.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

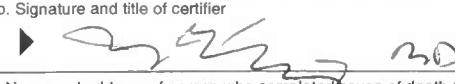
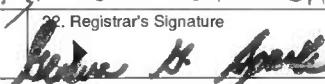
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 31 8

3. Time of Death

1- For State Registrar		2. Date of Death Month Day Year February 12 2007					
Physician /Medical Examiner		3. Time of Death 10:32 P M					
		1. Decedent's Name (First, Middle, Last) Wayne Lee Raber		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			
		4b. City, Town, or Location of Death Baltimore City		4c. County of Death			
Funeral Director		5. Social Security Number 219-68-1703	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11-26-56		
		10a. State MD.		10b. County Anne Arundel	10c. City, Town or Location PASADENA		
		10e. Street and Number 7824 A CATHERINE AVE.		10f. Zip Code 21122	10g. Citizen of What Country? U.S.A.		
		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RECYCLER			
		17. Father's Name (First, Middle, Last) FREDERICK C. RABER		18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH DOMIEKA			
		19a. Informant's Name/Relationship (Type, Print) TERESA H. RABER, WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1824 A CATHERINE AVE. PASADENA, MD. 21122			
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANATOMIC GEMS REGISTRY	Date 2-14-07		
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122			
Physician /Medical Examiner		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
		<p>a. Glioblastoma multiforme Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			
		23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hydrocephalus, pneumonia, pulmonary embolus, SIADH					
		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
		27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
		29b. Signature and title of certifier 		29c. License number D0063682		29d. Date signed (Month, Day, Year) February 12, 2007	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Koenig 660 N. Wolfe Street Baltimore, MD 21207					
		31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, W,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 349

1- For
State
RegistrarPhysician
/Medical
Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21268

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Norma Mae ALICIA Rogers		Feb 7 2007		223PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
UNIVERSITY OF MARYLAND MEDICAL CENTER		BALTIMORE		NIA	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar 31, 1937	9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10e. Street and Number 914 North Arlington Avenue		10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Machine Operator		16b. Kind of Business/Industry Gallant Belt Company	
17. Father's Name (First, Middle, Last) Robert Colvin		18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Colvin			
19a. Informant's Name/Relationship (Type, Print) Norma Brooks McRoy Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 North Smallwood Street Baltimore, Maryland 21216			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		Date 02/16/07	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee Eugene H. Waller		22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): Sepsis		b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29d. Date signed (Month, Day, Year) Feb 7 2007	
29b. Signature and title of certifier C. Rodriguez, Jr.		29c. License number 8142			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlos J. Rodriguez, Jr.		31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Laura G. Jones	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

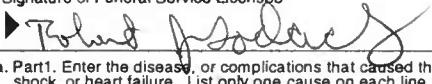
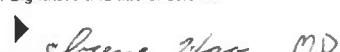
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04350

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death				
	Alvin H. Reisig						February 12 2007	5:32 AM				
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death					
	Sinai Hospital of Baltimore			Baltimore City								
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)				
	212-14-3371		84				Nov 16, 1922	Maryland				
Usual Residence of Decedent												
10a. State Md		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 107 Briarwood Road				10f. Zip Code 21222			10g. Citizen of What Country? USA					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Assembly Line Worker			16c. Date of Death			
17. Father's Name (First, Middle, Last) John C. Reisig				18. Mother's Name (First, Middle, Maiden Surname) Carrie E. Schutte					18d. Location - City or Town, State			
19a. Informant's Name/Relationship (Type, Print) Margaret Zagraiek/sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7184 White Richardson Rd Pittsville, Md 21850					19c. Date			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Batview Crematory			20c. Location - City or Town, State Baltimore, Maryland			20d. Date		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md 21222					22e. Approximate Interval Between Onset and Death 2 days			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									23b. Due to (or as a consequence of): a. Acute Bowel Perforation b. Ogilvie's Syndrome c. Due to (or as a consequence of): d. Due to (or as a consequence of): 23c. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	23f. Date		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide									28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier 	29c. License number RES-000	29d. Date signed (Month, Day, Year) February 12 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irene Hao, MD Sinai Hospital of Baltimore									31. Date filed (Month, Day, Year) FEB 14 2007	32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit envelope.

Medical Certification: To Be Completed by Physician/Medical Examiner

Patient known as Alvin Reisig
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or if items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

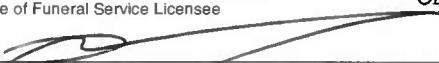
Reg. No.

2007 04351

1 - For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural" or items 25a or 28a+ show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

To Be Completed by Funeral Director

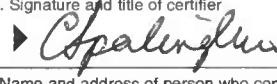
1. Decedent's Name (First, Middle, Last) JEANETTE A. REIP				2. Date of Death Month FEBRUARY Day 11 , Year 2007		3. Time of Death 9:35 A.M.	
4a. Facility Name (If not institution, give street and number) 1312 COLBURY ROAD APT. G				4b. City, Town, or Location of Death GLENMONT		4c. County of Death BALTIMORE	
5. Social Security Number 217-20-8676		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 7/20/1916	9. Birthplace (State or Foreign Country) MARYLAND
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location GLENMONT			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1312 COLBURY ROAD APT. G				10f. Zip Code 21239		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12)		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) 12TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TELEPHONE OPERATOR		16b. Kind of Business/Industry TELEPHONE CO.			
17. Father's Name (First, Middle, Last) CHARLES J. REIP				18. Mother's Name (First, Middle, Maiden Surname) ANNA E. BYRNE			
19a. Informant's Name/Relationship (Type, Print) CHARLES REIP/NEPHEW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 SHAFFNER DR. BEL AIR, MD 21014			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MOST HOLY REDEEMER		20b. Place of Disposition (Name of cemetery, crematory or other place) CEMETERY		Date 2/16/2007	20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286					

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 17 yrs.
<p>a. _____ Due to (or as a consequence of): <i>Atherosclerotic Cardiovascular disease</i></p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>				

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension hyperlipidemia				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--	--	--	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 					
--	--	--	--	--	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL SPERLING MD, 5601 LOCH RAVEN BLVD BALR. MD 21239		29c. License number D28987		29d. Date signed (Month, Day, Year) 2/12/2007		
--	--	--------------------------------------	--	---	--	--

31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature 				
---	--	--	--	--	--	--

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

Baltimore, Maryland 21215-0036



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

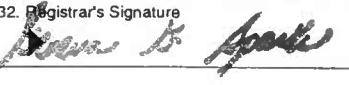
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 352

For
State
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death	
	Clifton Sawyer							Month Day Year		12:55 PM	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
	Northwest Hospital			Randallstown			Baltimore				
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)			
	229-16-7344		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	81 Yrs.	Months Days	Hours Min.	February 10, 1926	VA			
Usual Residence of Decedent											
10a. State	10b. County	10c. City, Town or Location							10d. Inside City Limits		
MD	Baltimore	Randallstown							1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?				
6877 Parsons Avenue				21207			USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: African Americans			
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12)		College (1-4 or 5+)		Title Setter			Self				
17. Father's Name (First, Middle, Last)											
unk											
18. Mother's Name (First, Middle, Maiden Surname)											
unk											
19a. Informant's Name/Relationship (Type, Print)											
Juanita Sawyer/wife											
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
6877 Parsons Ave Randallstown, MD 21207											
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State				
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Woodlawn Cem			2/20/07		Baltimore County, MD				
21. Signature of Funeral Service Licensee											
											
22. Name and Address of Funeral Service											
Hart P. Close Funeral Service, P. O. Box 5126, Belair Road, Baltimore, MD 21206											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death)											
a. Atherosclerotic Cardiovascular Disease											
Due to (or as a consequence of):											
b. Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. _____											
Approximate Interval Between Onset and Death											
IF FEMALE:		23c. If yes, outcome of pregnancy			23d. Date of delivery						
23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			Month Day Year						
23e. Did tobacco use contribute to the cause of death?											
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed?											
24b. Were autopsy findings available prior to completion of cause of death?											
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner?											
26. Place of Death (Check only one)											
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death											
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		M		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		_____		_____	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one)											
29b. Signature and title of certifier											
Jennifer Yorke DO											
29c. License number											
140055644											
29d. Date signed (Month, Day, Year)											
February 11 2007											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Jennifer Yorke 5401 Old Court Rd Randallstown, MD 21133											
31. Date filed (Month, Day, Year)		32. Registrar's Signature									
FEB 15 2007											

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04353

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, *EJ*

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death Hour:Minute AM/PM											
<i>Donald Smith</i>	<i>February 09 2007</i>	<i>11:41 M</i>											
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death											
<i>Harbor Hospital Center</i>	<i>Baltimore</i>	<i>N/A</i>											
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 9, 1935	9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent: 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Brooklyn Park 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
10e. Street and Number 641 Sunset Strip			10f. Zip Code 21225		10g. Citizen of What Country? U.S.A.								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White Specify:								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 Cab Driver		16b. Kind of Business/Industry Associated Cab. Co.								
17. Father's Name (First, Middle, Last) Harry Smith			18. Mother's Name (First, Middle, Maiden Surname) Hilda Hopkins										
19a. Informant's Name/Relationship (Type, Print) Barbara Ann Smith (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 Sunset Strip/ Baltimore, Maryland 21225										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 02-13-07	20c. Location - City or Town, State Baltimore, Maryland								
21. Signature of Funeral Service Licensee <i>James S. Yacynych</i>			22. Name and Address of Facility McCullly-Polyniak Funeral Home P.A. 21225 237 East Patapsco Avenue, Baltimore, Maryland										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <table border="1" style="margin-left: 100px;"> <tr> <td>a. <i>Hepatoperitoneal Hemorrhage</i> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 15 minutes</td> </tr> <tr> <td>b. <i>Aortic Abdominal Aneurysm Rupture</i> Due to (or as a consequence of):</td> <td>15 minutes</td> </tr> <tr> <td>c. <i>ASVOD</i> Due to (or as a consequence of):</td> <td>20 years</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>						a. <i>Hepatoperitoneal Hemorrhage</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death 15 minutes	b. <i>Aortic Abdominal Aneurysm Rupture</i> Due to (or as a consequence of):	15 minutes	c. <i>ASVOD</i> Due to (or as a consequence of):	20 years	d.	
a. <i>Hepatoperitoneal Hemorrhage</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death 15 minutes												
b. <i>Aortic Abdominal Aneurysm Rupture</i> Due to (or as a consequence of):	15 minutes												
c. <i>ASVOD</i> Due to (or as a consequence of):	20 years												
d.													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred								
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>Robert M. Yacynych MD</i>			29c. License number 00052022		29d. Date signed (Month, Day, Year) February 10 th , 2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Robert M. Yacynych MD</i>		31. Date filed (Month, Day, Year) FEB 15 2007 32. Registrar's Signature <i>[Signature]</i>											
33. Location (Street and Number or Rural Route Number, City or Town, State) 3001 Ansel Hanna St 21230													

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04354

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

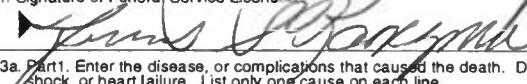
Smith, James G.
Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 26e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21268

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		JAMES G. SMITH				2. Date of Death Month Day Year	3. Time of Death
4a. Facility Name (If not institution, give street and number)		BALTIMORE WASHINGTON Medical Center		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
5. Social Security Number 215-28-3254		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 18, 1932	9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Pasadena			
10e. Street and Number 8093 Woodholme Circle				10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry Stationary Engineer		16c. Date of Death 02-14-07	
17. Father's Name (First, Middle, Last) John C. Smith				18. Mother's Name (First, Middle, Maiden Surname) Mary C. MacKenzie			
19a. Informant's Name/Relationship (Type, Print) Christine K. Barnett (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8093 Woodholme Circle, Pasadena, Maryland 21122			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem Park		20c. Location - City or Town, State Elkridge, Maryland		Date 02-14-07	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McGULLY-POLYNIAK Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							
a. URSOSEPSIS Due to (or as a consequence of):							
b. ACUTE RENAL FAILURE Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CANCER							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D 0060796		29d. Date signed (Month, Day, Year) FEB 15 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM KENNEDY, #305, 305 HOSPITAL DRIVE, GLEN BURNIE MD 21061							
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 					

State
Registrar

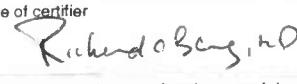
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04355

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death	
	Lambdin Lyle Shaw							February 13, 2007			4:00 A.M	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death			
	Rolling Meadows Nursing Home				Catonsville				Baltimore			
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months		If Under 24 Hrs. Days		8. Date of Birth (Month, Day, Year) 05/23/1922		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent												
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 303 N. Rolling Road				10f. Zip Code 21228				10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor				16b. Kind of Business/Industry Bakery				
17. Father's Name (First, Middle, Last) Leslie Shaw Sr.						18. Mother's Name (First, Middle, Maiden Surname) Mildred Naomi Lambdin						
19a. Informant's Name/Relationship (Type, Print) Karen Kelbel - Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Kingston Road Baltimore, Maryland 21229						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory				Date	20c. Location - City or Town, State 02/15/2007 Baltimore, Maryland			
21. Signature of Funeral Service Licensee 												
22. Name and Address of Facility David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229												
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death) c. <i>cardiac arrhythmia</i> Due to (or as a consequence of):												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>acute exacerbation of chronic bronchitis</i> Due to (or as a consequence of): c. <i>chronic bronchitis</i> Due to (or as a consequence of): d. _____												
Approximate Interval Between Onset and Death 1 hour 20 hours 10 years												
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown												
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____												
23d. Date of delivery Month Day Year												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 										
29c. License number D20604												
29d. Date signed (Month, Day, Year) 2/15/07												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg, MD, #450, 10755 Falls Rd, Lutherville, MD 21093												
31. Date filed (Month, Day, Year) FEB 15 2007												
32. Registrar's Signature 												

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-in-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04356

Reg. No.

For
State
Registrar

1-

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Elaine Stine	February 12 2007	1045 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Citizens Nursing Home	Havre De Grace	Harford

Funeral
Director

5. Social Security Number	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth Month, Day, Year Nov. 28, 1929	9. Birthplace (State or Foreign Country) Maryland
212-28-4045					

Usual Residence of Decedent
10a. State Maryland 10b. County Harford 10c. City, Town or Location Forest Hill
10e. Street and Number 324 E. Jarrettsville Rd. 10f. Zip Code 21050 10g. Citizen of What Country? USA
10d. Inside City Limits 1 Yes 2 No

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
Elementary/Secondary (0-12) 11	College (1-4 or 5+)	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier	16b. Kind of Business/Industry Retail Food			
17. Father's Name (First, Middle, Last) William Walton Kirby	18. Mother's Name (First, Middle, Maiden Surname) Elsie (nmn) Clark	19a. Informant's Name/Relationship (Type, Print) Diane Weih/Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 E. Jarrettsville Rd., Forest Hill, MD 21050	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Pk	Date 2-17-07	20c. Location - City or Town, State Sykesville, Maryland
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility McComas Funeral Home, P. A. 50 W. Broadway, Bel Air, Maryland 21014						

Baltimore, Maryland 21215-0036

et
Division of Vital Records, P.O. Box 68760,
Within 24 hours after death.
To the Hospital or Attending Physician: The law requires that the death certificate be executed
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORN CHANDRAS K. NAWR, M.D., 601 S. Union Ave., Laurel, page no 108	29c. License number D20218	29d. Date signed (Month, Day, Year) 2/13/2007		
31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04357

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM SWEENEY							2. Date of Death Month Day Year February 12, 2007			3. Time of Death 5:20 PM	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL			4b. City, Town, or Location of Death RANDALLSTOWN			4c. County of Death BALTIMORE					
Funeral Director	5. Social Security Number 216-68-8367	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) September 5, 1955	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Glen Burnie							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 1024 1st St. Apt. B			10f. Zip Code 21060			10g. Citizen of What Country? USA					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1968	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled			16b. Kind of Business/Industry N/A					
	17. Father's Name (First, Middle, Last) Homer Thomas Sweeney			18. Mother's Name (First, Middle, Maiden Surname) Katherine Virginia Hook								
	19a. Informant's Name/Relationship (Type, Print) Peggy Ann Haley / Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2933 Salem Bottom Rd Westminster, MD 21157								
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Burial			20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Gifts Registry			Date February 13, 2007	20c. Location - City or Town, State Hanover, MD				
	21. Signature of Funeral Service Licensee Bon			22. Name and Address of Facility Anatomy Gifts Registry								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):						Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			{ a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29d. Date signed (Month, Day, Year) FEBRUARY 12, 2007			
29b. Signature and title of certifier Michael Rothman, MD			29c. License number D43481									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ROTHMAN 5401 OLD COURT ROAD RANDALLSTOWN MARYLAND 21133												
31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature See back									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 49

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit envelope.

Important: If Item 27 is marked other than "natural", or Item 2a or 2b-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For
State
Registrar

Amend Item 23a per dr., G864, 02/15/07/dhb

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 04358

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Modesta L. Swoboda		January 15, 2007				5:10 A M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Genesis Eldercare		Brooklyn Park				Anne Arundel	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Jul. 21, 1928	9. Birthplace (State or Foreign Country) Maryland
6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Jul. 21, 1928	9. Birthplace (State or Foreign Country) Maryland	
10a. State MD		10b. County Anne Arundel	10c. City, Town or Location Brooklyn Park				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 613 Hammonds Lane		10f. Zip Code 21225				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Salvatore Costa		18. Mother's Name (First, Middle, Maiden Surname) Modesta Costa					
19a. Informant's Name/Relationship (Type, Print) Jacqueline Quoss - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Cottage Place, Red Lion, PA 17356					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Cathleen McRobert</i>		20b. Place of Disposition (Name of Cemetery, Cemetery or other place) Most Holy Redeemer Cemetery		Date 1-18-2007	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee <i>Cathleen McRobert</i>		22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 1 MONTH					
a. Due to (or as a consequence of): ACUTE RENAL FAILURE							
b. Due to (or as a consequence of): Diabetic Nephropathy		years					
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>9</i>		23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>4</i>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one)		29b. Signature and title of certifier <i>Brian C. Wallace MD</i>					
29c. License number D31136		29d. Date signed (Month, Day, Year) JANUARY 15, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>BRIAN C. WALLACE MD, 9005 KILBRIDE RD, BALTIMORE, MD 21256</i>							
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature <i>John H. Jones</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04359

1- For
State
RegistrarPhysician
/Medical
Examiner

To Be Completed by Funeral Director

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
Dorothy Eleanor Nesbitt Schwartz							February 8, 2007	9:25 a ^M
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
Gilchrist Hospice Center			Towson			Baltimore		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
272-09-9663			96 Yrs.		Sept. 21, 1910	New York		
Usual Residence of Decedent								
10a. State MD	10b. County Baltimore	10c. City, Town or Location Catonsville						
10e. Street and Number 706 Linda Drive			10f. Zip Code 21228			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Home Maker		16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Kent Arthur Nesbitt				18. Mother's Name (First, Middle, Maiden Surname) Mary Crane				
19a. Informant's Name/Relationship (Type, Print) Sandra Isbister/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4521 Hemlock Cone Way Ellicott City MD 21042				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory			Date 2-10-2007	20c. Location - City or Town, State Odenton, Maryland		
21. Signature of Funeral Service Licensee ► <i>Sandra L. Isbister</i>								
22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p style="text-align: right;">Approximate Interval Between Onset and Death <i>Acute Pneumonia w/ sepsis week</i></p> <p>a. Due to (or as a consequence of): <i>Acute Pneumonia w/ sepsis</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospital</i>			26. Place of Death (Check only one)		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>D25205</i>			29d. Date signed (Month, Day, Year) <i>February 8, 2007</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>W. A. R. Riley</i>							31. Date filed (Month, Day, Year) <i>FEB 15 2007</i>	
32. Registrar's Signature <i>James B. Aponte</i>							33. Signature and title of certifier <i>W. A. R. Riley, M.D.</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04360

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Elaine Janet Swanhart							2. Date of Death Month Day Year February 8, 2007	3. Time of Death 10:00a M
4a. Facility Name (If not institution, give street and number) 5618 Braxfield Road							4b. City, Town, or Location of Death Arbutus	4c. County of Death Baltimore
5. Social Security Number 219-60-2839		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 28, 1952	9. Birthplace (State or Foreign Country) Maryland	

Usual Residence of Decedent
10a. State
MD 10b. County
Baltimore 10c. City, Town or Location
Woodlawn

10d. Inside City Limits
 Yes No

10e. Street and Number
1439 Langford Rd. 10f. Zip Code
21207 10g. Citizen of What Country?
U.S.A.

11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Binder	14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United Book Press	16b. Kind of Business/Industry	

17. Father's Name (First, Middle, Last) William Whitehead	18. Mother's Name (First, Middle, Maiden Surname) Elaine Paradise		
19a. Informant's Name/Relationship (Type, Print) Leroy J. Swanhart/Husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Langford Rd. Baltimore MD 21207		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cemetery 2-12-2007	Date	20c. Location - City or Town, State Ellicott City, MD

21. Signature of Funeral Service License 	22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 7 mo
a. Due to (or as a consequence of): small cell lung cancer	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Sister's house		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D35254	29d. Date signed (Month, Day, Year) 2-9-07
29b. Signature and title of certifier 	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carole Miller MD 905 Caton Ave Blk 4 MD 21229	

31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature
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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04361

1- For
State
Registrar

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8 X1

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
William Jennings Selby, Jr.		February 10 2007		1352 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Shady Grove Adventist Hospital		Rockville		Montgomery
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) January 22, 1933
214-30-1353			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent				
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 202 England Terrace		10f. Zip Code 20850		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Korea If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Concrete
17. Father's Name (First, Middle, Last) Jennings Selby		18. Mother's Name (First, Middle, Maiden Surname) Evelyn McAtee		
19a. Informant's Name/Relationship (Type, Print) William R. Selby /Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Sanders Lane, Gaithersburg, Maryland 20877		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Oak Cemetery	Date February 16, 2007	20c. Location - City or Town, State Gaithersburg, Maryland
21. Signature of Funeral Service Licensee Angela Banerji		22. Name and Address of Facility Robert A. Pumphrey Funeral Home /Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death minutes		
a. Due to (or as a consequence of): Cardiac Dysrhythmia				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Amit Kalaria		29c. License number D64068		29d. Date signed (Month, Day, Year) February 10, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Kalaria 9901 Medical Center Drive Rockville MD 20850				
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Leanne B. Parker		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04362

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CRAIG MAURY SILVERSTEIN							2. Date of Death Month Day Year FEBRUARY 12, 2007	3. Time of Death 9:10 A M
	4a. Facility Name (If not institution, give street and number) 6 TAVERNGREEN COURT			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 218-46-1878	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 08/13/1950	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent MD BALTIMORE			10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 6 TAVERNGREEN COURT			10f. Zip Code 21209			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUILDING CONTRACTOR			16b. Kind of Business/Industry INSURANCE RESTORATION		
	17. Father's Name (First, Middle, Last) ARNOLD SILVERSTEIN				18. Mother's Name (First, Middle, Maiden Surname) SELMA GOLDMAN				
	19a. Informant's Name/Relationship (Type, Print) SHEILA SILVERSTEIN / WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 TAVERNGREEN COURT - BALTIMORE, MD 21209					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM			Date 02/13/2007	20c. Location - City or Town, State REISTERSTOWN, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): metastatic lung cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death 3 months</p>								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury : At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 			29c. License number 007930			29d. Date signed (Month, Day, Year) February 12, 2007		
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature 			ORIGINAL		

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

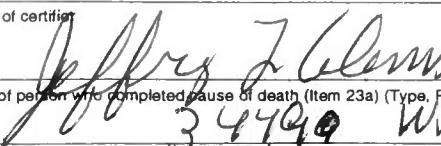
Within 24 hours after death
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 363
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Lou Smith							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 10:18A.M.
	4a. Facility Name (If not institution, give street and number) 407 Burbank Court			4b. City, Town, or Location of Death Lansdowne			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 234-66-8708		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct 5, 1941	9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent		10a. State Md. 10b. County Baltimore 10c. City, Town or Location Lansdowne					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 407 Burbank Court			10f. Zip Code 21227			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1941		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medicine Aid		16b. Kind of Business/Industry Nursing				
	17. Father's Name (First, Middle, Last) Carl Farmer		18. Mother's Name (First, Middle, Maiden Surname) Edward Smith (husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Burbank Court Lansdowne, Md 21227			
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Loudon Park		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park		Date 2-14-07	20c. Location - City or Town, State Baltimore, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Kaczorowski Funeral Home, PA		19c. Approximate Interval Between Onset and Death Minutes				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Ventricular Fibrillation			23c. Due to (or as a consequence of): Congestive Heart Failure			Approximate Interval Between Onset and Death 7 days
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Due to (or as a consequence of): Hypertension			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown			23d. Date of delivery Month Day Year			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 021512			29d. Date signed (Month, Day, Year) 2/12/07			
	29b. Signature and title of certifier 		29c. License number 021512			29d. Date signed (Month, Day, Year) 2/12/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Z. Adams		32. Registrar's Signature 			31. Date filed (Month, Day, Year) FEB 14 2007			
State Registrar									2/22/07

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 1 per PHYS., G864, 2/15/07 WS

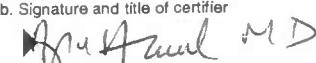
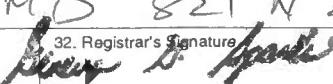
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04364

1- For
State
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Henry Tapp				2. Date of Death Month 2 Day 6 Year 07	3. Time of Death 0400 AM		
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A			
Funeral Director	5. Social Security Number 239-40-3052	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 02/10/1932	9. Birthplace (State or Foreign Country) N. CAROLINA	
Usual Residence of Decedent 10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1217 W. FAYETTE STREET				10f. Zip Code 21223		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: X		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAINTER		16b. Kind of Business/Industry CONSTRUCTION				
17. Father's Name (First, Middle, Last) JOSHUA TAPP				18. Mother's Name (First, Middle, Maiden Surname) MARTHA TAPP				
19a. Informant's Name/Relationship (Type, Print) BEATRICE SHAW / SISTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 W. SARATOGA ST, BALTIMORE, MD 21223						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) X		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM.		Date	20c. Location - City or Town, State LANSDOWNE, MD			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute MI		Approximate Interval Between Onset and Death						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe peripheral vascular disease								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure disorders		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
29b. Signature and title of certifier 		29c. License number D 39127		29d. Date signed (Month, Day, Year) 2/7/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. AHMED MD 821 N Eutaw ST. Baltimore MD 21201								
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04366
Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

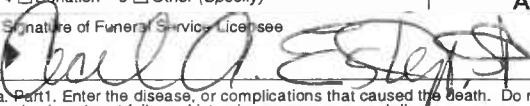
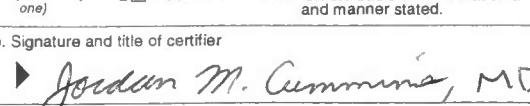
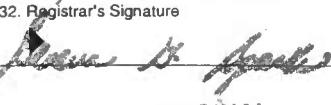
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Patient known as Patricia Tolson
Baltimore, Maryland

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Patricia Tolson		February 6 2007				12:00 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Sinai Hospital of Baltimore		Baltimore City				N/A	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec 6, 1951	9. Birthplace (State or Foreign Country) Maryland	
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 6110 Talles Road			10f. Zip Code 21207			10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Surgical Nurse		16b. Kind of Business/Industry Bon Secours Hospital			
17. Father's Name (First, Middle, Last) Walter Vaught			18. Mother's Name (First, Middle, Maiden Surname) Mary Vaught				
19a. Informant's Name/Relationship (Type, Print) Mary Vaught Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6110 Talles Road Baltimore, Maryland 21207			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		Date 02/10/07		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee 							
22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Hepatic Encephalopathy Due to (or as a consequence of): b. Liver failure Due to (or as a consequence of): c. Alcohol Abuse Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 week 3 years 10 years							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES-000					
29d. Date signed (Month, Day, Year) February 6, 2007							
29b. Signature and title of certifier 		29c. License number RES-000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jordan M. Cummins, MD Sinai Hospital of Baltimore							
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007

Certificate of Death

Req. No.

04367

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) LEOLA WATSON						2. Date of Death Month Day Year FEB. 12 2007		3. Time of Death 18:03 M	
Funeral Director		4a. Facility Name (If not institution, give street and number) 751 W. SARATOGA STREET						4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
To Be Completed by Funeral Director		5. Social Security Number 219-22-3871		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 11/11/1926	9. Birthplace (State or Foreign Country) VIRGINIA		
		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE CITY				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 751 W. SARATOGA STREET				10f. Zip Code 21201			10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: XX		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1 YR			16b. Kind of Business/Industry STATE GOVERNMENT NEW YORK			
		17. Father's Name (First, Middle, Last) UNK				18. Mother's Name (First, Middle, Maiden Surname) COREELIA WATSON					
		19a. Informant's Name/Relationship (Type. Print) SABRINA ELLIOTT/DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6132 MARLORA RD, BALTIMORE, MD 21239						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>KING MEMORIAL PK</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PK			Date 2/21/07	20c. Location - City or Town, State WINDSOR MILL, MD		
		21. Signature of Funeral Service Licensee <i>Jason Black</i>			22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD						
Physician /Medical Examiner		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat. Cause (Final disease or condition resulting in death) Myocardial Infarct Approximate Interval Between Onset and Death Minutes									
		23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant In the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____									
		23d. Date of delivery Month Day Year									
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier <i>Jason Black MD</i>		29c. License number D0061199				29d. Date signed (Month, Day, Year) Feb. 13, 2007			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Black 6565 North Charles St, Suite 207, Towson MD 21204									
State Registrar		31. Date filed (Month, Day, Year) FFB 15 2007		32. Registrar's Signature <i>Jason B. Apelt</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are legible.
 Amend Item 11 per spouse, if applicable. Item 18/19/2007

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04368

1- For State
RegistrarPhysician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	RACHEAL MICHELLE WILSON				2. Date of Death Month Day Year	3. Time of Death 1248 hrs
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Reg. No.

Funeral
Director

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
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5. Social Security Number 436-33-6263	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 12/27/1977	9. Birthplace (State or Foreign Country) LOUISIANA
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Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location BALTIMORE CITY						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 424 HOWILL TERRANCE	10f. Zip Code 21218	10g. Citizen of What Country? USA
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11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) FIREFIGHTER CADET	16b. Kind of Business/Industry CITY OF BALTIMORE
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17. Father's Name (First, Middle, Last) RONNIE MURRAY	18. Mother's Name (First, Middle, Maiden Surname) VIRGINIA WILSON
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19a. Informant's Name/Relationship (Type, Print) VIRGINIA SLAUGHTER / MOTHER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19345 E. ADA PL, DENVER, COLORADO 80249
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: FAIRMONT CEMETERY	20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRMONT CEMETERY	Date 2/22/07	20c. Location - City or Town, State DENVER, COLORADO
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21. Signature of Funeral Service Licensee <i>Judge D. L. Murray</i>	22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AV, BALTIMORE, MD
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Immediate Cause (Final disease or condition resulting in death) b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d.	Approximate Interval Between Onset and Death
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a. Immediate Cause (Final disease or condition resulting in death) b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d.	Approximate Interval Between Onset and Death
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<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #23a,27,28a-f, per ME, g864, 2/21/07 TT	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
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23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other	26. Place of Death (Check only one)
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Fnd 2/9/2007	28b. Time of Injury 11:47 am	28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Firefighter injured during training exercise	28d. Describe how injury occurred Firefighter injured during training exercise
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Dwelling	28f. Location (Street and Number or Rural Route Number, City or Town, State) 143 S. Calverton Rd. Baltimore, MD
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29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 10, 2007
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30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201
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31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature <i>Patricia Aronica - Pollak</i>
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Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04369

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Weber					2. Date of Death Month Day Year February 13 2007	3. Time of Death 10:15PM	
	4a. Facility Name (If not institution, give street and number) Pickersgill			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-07-8591	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 12, 1917	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State Maryland					10b. County Baltimore	10c. City, Town or Location Towson	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 615 Chestnut Ave.			10f. Zip Code 21204		10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary		16b. Kind of Business/Industry health insurance			
	17. Father's Name (First, Middle, Last) John Leonard Weber			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Weissner				
	19a. Informant's Name/Relationship (Type, Print) William Gyr/cousin			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1966 Almond Dr. Finksburg, MD 21048				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date Feb. 17, 2007	20c. Location - City or Town, State Parkville, Maryland		
	21. Signature of Funeral Service Licensee John O. Mitchell			22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Urinary Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death days
	<p>a. Due to (or as a consequence of): Urinary Sepsis</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. coronary artery disease, osteoporosis, rectal bleeding							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28c. Injury at Work? M 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier M. Anthony Riley, MD							29c. License number D.75205
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GUMC 6701 N Charles St. Balto. Md 21201							29d. Date signed (Month, Day, Year) February 14, 2007
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature James B. Parker				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician/ Medical Examiner		Registrar 1. Decedent's Name (First, Middle, Last) Susan Lynn Ward						2. Date of Death Month Day Year February 7, 2007	3. Time of Death 1221 hrs		
Funeral Director		4a. Facility Name (if not institution, give street and number) St. Agnes Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A			
To Be Completed by Funeral Director		5. Social Security Number 213-02-1492		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34	Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) Dec. 4, 1972	9. Birthplace (State or Foreign Country) DC	
		Usual Residence of Decedent		10a. State MD		10b. County Baltimore		10c. City, Town or Location Arbutus		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 5609 Selford Road		10f. Zip Code 21227		10g. Citizen of What Country? United States					
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>If Yes, give Year or Dates:</small>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>Specify:</small>		14. Race - American Indian, Black, White, etc. White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry Disabled					
		17. Father's Name (First, Middle, Last) Charles P. Ward, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Joan D. Graff							
		19a. Informant's Name/Relationship (Type, Print) Charles P. Ward - Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5609 Selford Road, Arbutus, MD 21227							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donorship <input type="checkbox"/> Other Specify: <i>West Arundel Crematory</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory		Date 2-13-2007	20c. Location - City or Town, State Odenton, MD				
		21. Sign at _____ of Funeral Service _____ <i>Charles P. Ward, Jr.</i>		22. Name and Address of Facility Ambrose Funeral Home, Inc. 11328 Sulphur Spring Rd., Arbutus, MD 21227							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac, respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death									
a. Narcotic intoxication Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED <i>#28a,27,28a-f, per ME, G865, 3/7/07 TT</i>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:									
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Fnd 2/7/2007		28b. Time of Injury unk.	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unk					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home								28f. Location (Street and Number or Rural Route Number, City or Town, State) 5609 Selford Rd., Baltimore, MD	
29b. Signature and title of certifier <i>S. Locke</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 8, 2007							
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature <i>M. J. [Signature]</i>									
State Registrar											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04371

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emma J. Wehrenberg					2. Date of Death Month Day Year February 11, 2007	3. Time of Death 6:30 AM
	4a. Facility Name (If not institution, give street and number) Manor Care Potomac			4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 309-01-3962	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (Month, Day, Year) Feb. 22, 1918	9. Birthplace (State or Foreign Country) Indiana
	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery			10c. City, Town or Location Bethesda			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 6028 Chatsworth Lane				10f. Zip Code 20814		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Teacher			16b. Kind of Business/Industry Public Schools	
17. Father's Name (First, Middle, Last) Harry Fickle				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Stamper			
19a. Informant's Name/Relationship (Type, Print) John Alan Wehrenberg / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6028 Chatsworth Lane, Bethesda, Maryland 20814			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Montgomery Crematorium, Inc			20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc		Date February	20c. Location - City or Town, State Bethesda, Maryland	
21. Signature of Funeral Service Licensee Truong Bao			22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):</p> <p>b. CONGESTIVE HEART FAILURE Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier Truong Bao, MD.		29c. License number DO057124		29d. Date signed (Month, Day, Year) 2/12/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD. 9715 Medical Center Drive, Rockville, Maryland 20814							
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature Leanne B. Bao					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.													
State of Maryland / Department of Health and Mental Hygiene													
Certificate of Death													
Reg. No. 2007 04372													
1- For State Registrar		1. Decedent's Name (First, Middle, Last) LUVENIA R. WARE 4a. Facility Name (If not institution, give street and number) FUTURECARE CANTON 5. Social Security Number 212-28-2302 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F 7. Age (In yrs. last birthday) 86 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09-26-1920 9. Birthplace (State or Foreign Country) VA										3. Time of Death 3:35 A M	
Physician /Medical Examiner		4b. City, Town, or Location of Death BALTIMORE 4c. County of Death											
Funeral Director		10a. State MD 10b. County BALTIMORE 10c. City, Town or Location DUNDALK 10e. Street and Number 2704 DUNWALL CT. 10f. Zip Code 21222 10g. Citizen of What Country? USA										10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REGISTERED NURSE 16b. Kind of Business/Industry HEALTH INDUSTRY										13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK	14. Race - American Indian, Black, White, etc.
Physician /Medical Examiner		17. Father's Name (First, Middle, Last) WILLIAM CLINTON 18. Mother's Name (First, Middle, Maiden Surname) MILDRED NEBLETT/NIECE 19a. Informant's Name/Relationship (Type, Print) MILDRED NEBLETT/NIECE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 CHESTNUT ST., BALTIMORE, MD 21222											
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 21. Signature of Funeral Service Licensee 										20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILLS MEM. 20c. Location - City or Town, State 02/17/2007 MIDDLE RIVER, MD	
Medical Certification: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last										Approximate Interval Between Onset and Death 10 yr	
Medical Certification: To Be Completed by Physician/Medical Examiner		a. CONGLOMULARY ARTERY DISEASE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____											
Medical Certification: To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year											
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE MYELOMA 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
Medical Certification: To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide											
Medical Certification: To Be Completed by Physician/Medical Examiner		28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
Medical Certification: To Be Completed by Physician/Medical Examiner		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Medical Certification: To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier 											
Medical Certification: To Be Completed by Physician/Medical Examiner		29c. License number 042945 29d. Date signed (Month, Day, Year) FEB 12 2007											
Medical Certification: To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANS AERIN LARSON 705 ASIAN DRIVE TOWSON MD 21204											
Medical Certification: To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) FEB 15 2007 32. Registrar's Signature 											

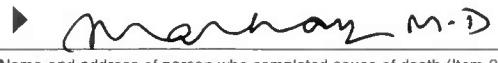
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04373
Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Glenn Harry Wheeler							2. Date of Death Month Day Year February 10, 2007	3. Time of Death 2:55A M
	4a. Facility Name (If not institution, give street and number) Cranberry Cottage			4b. City, Town, or Location of Death Pasadena			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 220-74-3433		6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 27, 1958	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent		10a. State MD 10b. County Anne Arundel			10c. City, Town or Location Ferndale			10d. Inside City Limits 1 □ Yes 2 X No
To Be Completed by Funeral Director	10e. Street and Number 1010 Big Baer Drive			10f. Zip Code 21061			10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Automotive				
	17. Father's Name (First, Middle, Last) Earl Harry Wheeler Sr.			18. Mother's Name (First, Middle, Maiden Surname) Gloria Viola Eckardt					
	19a. Informant's Name/Relationship (Type, Print) Mr. Earl H. Wheeler Sr/Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Big Baer Drive Ferndale Maryland 21061					
Physician /Medical Examiner	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date Feb. 15, 2007	20c. Location - City or Town, State Elkridge, MD			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee  MO1459		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Approximate Interval Between Onset and Death 3 months								
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Brain Metastases								
	c. Due to (or as a consequence of): Due to (or as a consequence of):								
	d. Due to (or as a consequence of): Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? X Yes 2 □ No 3 □ Probably 4 □ Unknown								
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) Assistant to Dr. M. D.						
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred Assistants to Dr. M. D.		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home								
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 21061								
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 39505						
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) February 12, 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Markan 305 Hospital Dr. Glen Burnie, MD. 21061								
State Registrar	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04374

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSE G. WAGNER							2. Date of Death Month Day Year FEB. 9, 2007	3. Time of Death 4:52 P M		
	4a. Facility Name (If not institution, give street and number) CARROLL HOSPICE - DOVE HOUSE			4b. City, Town, or Location of Death WESTMINSTER			4c. County of Death CARROLL				
Funeral Director	5. Social Security Number 219-34-4913	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 3/6/1935	9. Birthplace (State or Foreign Country) MARYLAND				
To Be Completed by Funeral Director	10a. State MD			10b. County CARROLL			10c. City, Town or Location WESTMINSTER		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1807 BOLLINGER RD.			10f. Zip Code 21157			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) FACTORY WORKER			16b. Kind of Business/Industry MANUFACTURING				
	17. Father's Name (First, Middle, Last) JESSE HARVEY WAGNER					18. Mother's Name (First, Middle, Maiden Surname) MILDRED CATHERINE GESELL					
	19a. Informant's Name/Relationship (Type, Print) LINDA K. WAGNER - WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 BOLLINGER RD., WESTMINSTER, MD 21157			19c. Date			20c. Location - City or Town, State WESTMINSTER, MD	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) KRIDER'S CEMETERY			20b. Place of Disposition (Name of cemetery, crematory or other place) 2/12/07			20c. Date			20c. Location - City or Town, State WESTMINSTER, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
	<p>a. <i>Non-Hodgkin Lymphoma</i> Due to (or as a consequence of):</p> <p>b. <i>CARCINOMATOS MENINGITIS</i> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9/ Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 		29c. License number 063071			29d. Date signed (Month, Day, Year) 2/12/2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. GAFFAR		31. Date filed (Month, Day, Year) FEB 15 2007								
	32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04375

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last) ALBERT WINKLER						2. Date of Death Month FEBRUARY Day 12 Year 2007		3. Time of Death 5:56 PM				
		4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL						4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE				
		5. Social Security Number 555-36-4161		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>		If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
		8. Date of Birth (Month, Day, Year) 04/30/1928						9. Birthplace (State or Foreign Country) CA						
		10a. State MD						10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS				
		10e. Street and Number 4730 ATRIUM COURT #108						10f. Zip Code 21117		10g. Citizen of What Country? USA				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 4 CERTIFIED PUBLIC ACCOUNTANT			16b. Kind of Business/Industry ACCOUNTING			
		17. Father's Name (First, Middle, Last) ALBERT WINKLER						18. Mother's Name (First, Middle, Maiden Surname) KATIE BRANNAN						
		19a. Informant's Name/Relationship (Type, Print) JANITH LICHTMAN / DAUGHTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3408 FIELDING ROAD - BALTIMORE, MD 21208						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>SHAAREI ZION CEMETERY</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) SHAAREI ZION CEMETERY			Date 2/14/2007		20c. Location - City or Town, State ROSEDALE, MD				
		21. Signature of Funeral Service Licensee <i>Scott M. Cutler</i>						22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS						Approximate Interval Between Onset and Death						
		b. Due to (or as a consequence of): SEPSIS												
		c. Due to (or as a consequence of):												
		d. Due to (or as a consequence of):												
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE DIABETES MELLITUS						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29d. Date signed (Month, Day, Year) FEBRUARY 12 2007			
		29b. Signature and title of certifier <i>Averahalli M Harish</i> PHYSICIAN			29c. License number D42723									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVVERAHALLI M HARISH			31. Date filed (Month, Day, Year) FEB 15 2007						32. Registrar's Signature <i>John B. Jones</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 31 per dvr g864 2-14-07 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04376

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTIN F. YANNUZZI				2. Date of Death Month FEBRUARY Day 11 , Year 2007	3. Time of Death 8:45 P. M	
	4a. Facility Name (If not institution, give street and number) 8507 WILLOW OAK ROAD		4b. City, Town, or Location of Death RIDGELEIGH		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 215-16-9834	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 84	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 8/22/1922	9. Birthplace (State or Foreign Country) PENNSYLVANIA
Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE 10c. City, Town or Location PARKVILLE 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 8507 WILLOW OAK ROAD				10f. Zip Code 21234		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TV ENGINEER			16b. Kind of Business/Industry TELEVISION	
17. Father's Name (First, Middle, Last) CARMINE YANNUZZI				18. Mother's Name (First, Middle, Maiden Surname) MARIA CAPPARELLI			
19a. Informant's Name/Relationship (Type, Print) CONSTANCE R. YANNUZZI/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8507 WILLOW OAK ROAD BALTIMORE, MD 21234			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. GARDENS		Date 2/15/2007	20c. Location - City or Town, State COCKEYSVILLE, MD
21. Signature of Funeral Service Licensee ►							
22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. METATATIC PROSTATE CANCER Due to (or as a consequence of):</p> <p>b. ASCVD Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death >1yr</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier ► Edward P. Costlow M.D.		29c. License number D19503		29d. Date signed (Month, Day, Year) 2-12-07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.P. COSTLOW M.D. 10 GERARD Ave 214 TIMONIUM MD 21093							
31. Date filed (Month, Day, Year) 2-12-07		32. Registrar's Signature Febe 14 2007					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/1
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04377

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death P				
Elick (mn) Zak	Feb 08 2007	10:35 M				
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
Bel Air Health and Rehabilitation Center	Bel Air	HARFORD				
5. Social Security Number	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 12, 1919	9. Birthplace (State or Foreign Country) Texas
450-03-3944		87				

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Maryland	Harford	Abingdon	
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
908 Hilltop Avenue	21009	USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year of Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Project Planning Estimator	16b. Kind of Business/Industry U.S. Government	
17. Father's Name (First, Middle, Last) John (unk) Zak	18. Mother's Name (First, Middle, Maiden Surname) Frances (unk) (unk)		
19a. Informant's Name/Relationship (Type. Print) Jack Grisson / Friend	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1939 Bennett Rd. Box H9 Aberdeen, MD 21001		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.	Date	20c. Location - City or Town, State Towson, Maryland
21. Signature of Funeral Service Licensee ▶ Stephen A. Neugly	22. Name and Address of Facility McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009		

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. Due to (or as a consequence of): Community Acquired Pneumonia	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic Obstructive Pulmonary Disease chronic Atrial Fibrillation Diastolic Dysfunction	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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29b. Signature and title of certifier ▶ Manuel M. Elick, MD	29c. License number D19583	29d. Date signed (Month, Day, Year) February 9, 2007
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manuel M. Elick, MD	31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature ▶ Karen A. Baile
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State Registrar	ORIGINAL
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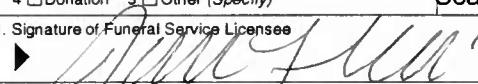
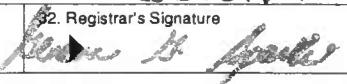
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, *ZAK ELLICK*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar		State of Maryland / Department of Health and Mental Hygiene		Amend Item 24a per verb., 884,02/15/07/dp Certificate of Death		Reg. No. 2007 04379			
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Atkinson					2. Date of Death Month 02 Day 08 Year 2007	3. Time of Death 0050 M		
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL		4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY			
Funeral Director	5. Social Security Number 212-24-0486	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec 20, 1929	9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany	10c. City, Town or Location Cumberland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 508 Paca Street			10f. Zip Code 21502		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) cabinet-maker			16b. Kind of Business/Industry Cabinet Company			
	17. Father's Name (First, Middle, Last) Harry Atkinson				18. Mother's Name (First, Middle, Maiden Surname) Edith Wilkins Atkinson				
	19a. Informant's Name/Relationship (Type, Print) Alice Isner		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Sheridan Pl. PO Box 263 Cumberland MD 21502						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Scarpelli Funeral Home, P.A.		20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home, P.A.		Date 2/8/2007	20c. Location - City or Town, State Cresaptown MD			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue, Cumberland, MD 21502						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	a. ATHEROSCLEROTIC VASCULAR DISEASE Due to (or as a consequence of): b. DIABETES Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
	Approximate Interval Between Onset and Death 5 YEARS								
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number D36766			29d. Date signed (Month, Day, Year) February 8, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIK Poonai, 924 Seton Dr. Cumberland, MD 21502								
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04380

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
MICHELE ABERDEEN-HENDERSON		JANUARY 23 2007				1545 M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
THE JOHNS HOPKINS HOSPITAL		BALTIMORE CITY					
5. Social Security Number 579-84-8863		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 14, 1968	9. Birthplace (State or Foreign Country) Trinidad, WI
Usual Residence of Decedent		10a. State Maryland 10b. County Prince Georges				10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
		10c. City, Town or Location Suitland					
10e. Street and Number 2305 Whitehall Street		10f. Zip Code 20746				10g. Citizen of What Country? Trinidad	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry Pharmacy Technician		16c. Location - City or Town, State Kaiser Permanente	
17. Father's Name (First, Middle, Last) Horace A. Aberdeen				18. Mother's Name (First, Middle, Maiden Surname) Linda L. Rivas			
19a. Informant's Name/Relationship (Type, Print) Reginald Henderson (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Whitehall St., Suitland, MD 20746					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.		Date 1/30/2007	20c. Location - City or Town, State Silver Spring, MD		
21. Signature of Funeral Service Licensee Andre Thompson		22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. 20012					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK Due to (or as a consequence of): b. CANDIDEMIA Due to (or as a consequence of): c. ACUTE LYMPHOBLASTIC LEUKEMIA Due to (or as a consequence of): d.							
Approximate Interval Between Onset and Death 3 DAYS 2 WEEKS 11 MONTHS							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier AMIR KASHANI, MEDICAL DOCTOR		29c. License number RES-000				29d. Date signed (Month, Day, Year) JANUARY 23, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KASHANI, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, MARYLAND 21205							
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Amir Kashani					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 01 381

Reg. No.

1- For
State
Registrar

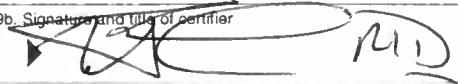
Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1- For State Registrar		Decedent's Name (First, Middle, Last) Edwin S. Addison							2. Date of Death Month Day Year January 30, 2007	3. Time of Death 7:35 AM	
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) 3228 Ludham Dr.			4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 216 28 5548	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 3/24/1931	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Silver Spring 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		10e. Street and Number 3228 Ludham Dr.			10f. Zip Code 20906			10g. Citizen of What Country? USA			
Physician /Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc.						
Medical Certification: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Self Employed	16b. Kind of Business/Industry Pest Control							
		17. Father's Name (First, Middle, Last) Edwin S. Addison	18. Mother's Name (First, Middle, Maiden Surname) Anna Neuberger								
		19a. Informant's Name/Relationship (Type, Print) Jean Addison/wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3228 Ludham Dr. Silver Spring, MD 20906	Date	20c. Location - City or Town, State Catonsville, MD						
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metro Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place)	22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Fk. Ellicott City, MD 21043							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure.					Approximate Interval Between Onset and Death 15 yrs.				
		a. Due to (or as a consequence of): Aortic stenosis									
		b. Due to (or as a consequence of): Cardiomyopathy					24 yrs				
		c. Due to (or as a consequence of): 									
		d. Due to (or as a consequence of): 									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diseased				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) 1/30/2007	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State) COLUMBIA MD 21047			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D18047		29d. Date signed (Month, Day, Year) 1/30/2007						
		29b. Signature and title of certifier 									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL REEDER MD 4540 KNOB NORTH DR									
		31. Date filed (Month, Day, Year) JAN 31 2007	32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item 1 - For State Registrar #26, per/physician, 1/31/07, B. Certificate of Death WCHD

2007 04 382
Reg. No.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) FAYE A. ARNOLD			2. Date of Death Month 01 Day 26 Year 07		3. Time of Death 0010 M
Funeral Director		4a. Facility Name (If not institution, give street and number) COSTAL HOSPICE at the LAKE			4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
To Be Completed by Funeral Director		5. Social Security Number 288-22-7090			6. Sex 1 □ M 2 X F	7. Age (In yrs. last birthday) 79 Yrs.	8. Date of Birth (Month Day Year) 07/15/1927
		9. Birthplace (State or Foreign Country) MA					
		10a. State MD			10b. County Worcester	10c. City, Town or Location Ocean Pines	10d. Inside City Limits 1 □ Yes 2 X No
		10e. Street and Number 42 Battersea Road			10f. Zip Code 21811		10g. Citizen of What Country? USA
		11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Homemaker
		17. Father's Name (First, Middle, Last) Wilfred Orin Aldrich			18. Mother's Name (First, Middle, Maiden Surname) Gunhild Grusell		
		19a. Informant's Name/Relationship (Type, Print) Stanley Arnold (spouse)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Battersea Road Ocean Pines, MD 21811		
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sunset Memorial Pk.			Date 01/30/2007	20c. Location - City or Town, State Berlin, MD	
		21. Signature of Funeral Service Licensee [Signature]			22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811		
Physician /Medical Examiner		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death		
		<p>a. Due to (or as a consequence of): Cardio myopathy</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown			23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		
					23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown		
					24a. Was an autopsy performed? 1 □ Yes 2 X No		
					24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No		
		25. Was case referred to medical examiner? 1 □ Yes 2 X No			26. Place of Death (Check only one) 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)		
		27. Manner of Death 1 X Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 5 □ Pending investigation 6 □ Could not be determined			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
		29b. Signature and title of certifier [Signature]			29c. License number 026278		29d. Date signed (Month, Day, Year) 1-26-07
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David E. Coull, MD Coastal Hospice PO Box 1733 Salis, MD 21802					
		31. Date filed (Month, Day, Year) FEB 01 2007			32. Registrar's Signature [Signature]		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04 383

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
MABLE ELIZABETH AMBUSH		JANUARY 28, 2007		11:50P M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
FREDERICK MEMORIAL HOSPITAL		FREDERICK		FREDERICK
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min.
214-19-8887				
8. Date of Birth (Month, Day, Year) June 28, 1925		9. Birthplace (State or Foreign Country) MD.		
Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
MD. FREDERICK		FREDERICK		
10e. Street and Number 1509 CEDAR CREST LANE		10f. Zip Code 21702		10g. Citizen of What Country? U. S. A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
Elementary/Secondary (0-12) 12		College (1-4 or 5+)		14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry MONTGOMERY COUNTY SCHOOL SYSTEM
17. Father's Name (First, Middle, Last) Lawrence Thomas		18. Mother's Name (First, Middle, Maiden Surname) Mary Thomas		
19a. Informant's Name/Relationship (Type, Print) Robert Howard Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 CEDAR CREST LANE FRED. MD. 21701		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, cemetery or other place) FAIRVIEW CEM		Date Feb. 3, 2007
21. Signature of Funeral Service Licensee ▶ Gary L. Rollins		22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 W. SOUTH ST. FRED. MD. 21701		20c. Location - City or Town, State FREDERICK MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Sepsis		Approximate Interval Between Onset and Death DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): Hypoxia		DAYS
{		23d. Due to (or as a consequence of): Respiratory Failure		DAYS
d.		23e. Due to (or as a consequence of): Pneumonia		DAYS.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29e. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier ▶		29c. License number 00062223		29d. Date signed (Month, Day, Year) 1/29/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRAVEEN BALARUM, MD		31. Date filed (Month, Day, Year) FEB 02 2007		
32. Registrar's Signature Suman B. Balarum				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04384

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Charles Anderson</i>				2. Date of Death Month Day Year <i>January 26, 2007</i>	3. Time of Death <i>8:30 A.M.</i>		
	4a. Facility Name (If not institution, give street and number) Ellicott City Healty & Rehab		4b. City, Town, or Location of Death Ellicott City		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 218-14-9304	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 11, 1924	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State MD		10b. County Howard		10c. City, Town or Location Columbia		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 9250 Coleman Thomas Road			10f. Zip Code 21046		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 43-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Robert E. Anderson			18. Mother's Name (First, Middle, Maiden Surname) Virgie Holland				
	19a. Informant's Name/Relationship (Type, Print) Rosalie E. Anderson (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9250 Coleman Thomas Rd, Columbia, MD 21046					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>MD Veterans Cem</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cem		Date 2/5/07	20c. Location - City or Town, State Crownsville, MD		
	21. Signature of Funeral Service Licensee <i>George L. Snowden</i>		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	a. Due to (or as a consequence of): <i>Atherosclerotic Cardiovascular Disease</i>							
	b. Due to (or as a consequence of): <i>Seizure Disorder</i>							
	c. Due to (or as a consequence of): <i>Bacterial Pneumonia</i>							
	d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Ramach Saba Pathi</i>				29c. License number D 30641		29d. Date signed (Month, Day, Year) January 26, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramach Saba Pathi 201-109 Beck River Neck Road Baltimore, MD 21221							
	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature <i>James K. Jones</i>					

Division or Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Baltimore, Maryland 21215-0036

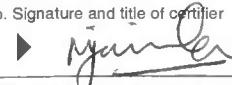
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04385

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD LEE ADAMS					2. Date of Death Month Day Year January 28 2007	3. Time of Death 17:20 P.M.	
	4a. Facility Name (If not institution, give street and number) Civista Medical Center			4b. City, Town, or Location of Death La Plata, MD		4c. County of Death Charles		
Funeral Director	5. Social Security Number 216-40-5734	6. Sex XXM	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 10, 1943	9. Birthplace (State or Foreign Country) WASH., DC	
	Usual Residence of Decedent MARYLAND CHARLES			10c. City, Town or Location NEWBURG			10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	
To Be Completed by Funeral Director	10e. Street and Number 15590 WOODLAND PT. RD.			10f. Zip Code 20664		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1960		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) APPLIANCE TECHNICIAN		16b. Kind of Business/Industry METROPOLITAN SVCS.		
	17. Father's Name (First, Middle, Last) MALCOMB CRAWFORD			18. Mother's Name (First, Middle, Maiden Surname) ELTA VIRGINIA MOATS				
	19a. Informant's Name/Relationship (Type, Print) MARY R. ADAMS-SPOUSE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15590 WOODLAND PT.RD., NEWBURG, MD 20664				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) METROPOLITAN CREMATORY 1-30-07			20b. Place of Disposition (Name of cemetery, crematory or other place) MONTAUK		Date RAYMOND FUNERAL SERVICE, P.A.	20c. Location - City or Town, State ALEXANDRIA, VA	
	21. Signature of Funeral Service Licensee 			Name and Address of Facility LA PLATA, MARYLAND 20646				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory insufficiency							Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of): Pleural Effusion							
	c. Due to (or as a consequence of): Non Small Cell Carcinoma (Metastasis)							
	d. Due to (or as a consequence of): CHF							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  MD			29c. License number D-005 7999		29d. Date signed (Month, Day, Year) 1/29/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manisha J. Jawaheer Prime Care America 11637 Terra Drive Suite 18 Waldorf, MD 20602							
State Registrar	31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For Amend #17 Per FH C865 3/02/07 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04386

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE - BROWN							2. Date of Death Month Day Year January 28 2007	3. Time of Death 10:19 P M			
	4a. Facility Name (If not institution, give street and number) 22305 FITZGERALD DRIVE			4b. City, Town, or Location of Death LAYTONSVILLE			4c. County of Death MONTGOMERY					
Funeral Director	5. Social Security Number 297-18-8709		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 28 1924	9. Birthplace (State or Foreign Country), Ohio				
	Usual Residence of Decedent 10a. State Md. 10b. County Montgomery 10c. City, Town or Location Laytonsville								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 22305 Fitzgerald Drive				10f. Zip Code 20882			10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1942 - If Yes, Give Year or Dates: 1969		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5			16b. Kind of Business/Industry Business Owner Telecommunications					
	17. Father's Name (First, Middle, Last) Brown George Thomas Baker				18. Mother's Name (First, Middle, Maiden Surname) Hannah Douglas							
	19a. Informant's Name/Relationship (Type, Print) Juliana C. Brown / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22305 Fitzgerald Drive, Laytonsville, Md. 20882								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National			Date 3/13/07	20c. Location - City or Town, State Arlington, Virginia				
	21. Signature of Funeral Service Licensee Muriel H. Barber			22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Parkinson's disease Due to (or as a consequence of):								Approximate Interval Between Onset and Death			
	b. _____ Due to (or as a consequence of):											
	c. _____ Due to (or as a consequence of):											
	d. _____											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home								28f. Location (Street and Number or Rural Route Number, City or Town, State) Rockville, MD 20855			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier Cynthia M. Williams DO			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd								29c. License number H0058032			
	31. Date filed (Month, Day, Year) JAN 31 2007								32. Registrar's Signature [Signature]			

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

10+1

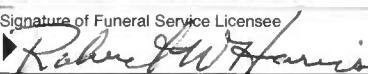
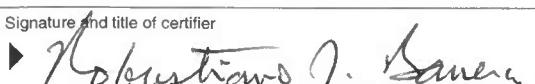
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04387

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theresa Broadwater					2. Date of Death Month 02 Day 05 Year 07	3. Time of Death 0300 M
	4a. Facility Name (If not institution, give street and number) WMHS-Braddock Campus			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 215-74-9068	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sep 8 1912	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Westernport						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 20314 John Baker Rd				10f. Zip Code 21562		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)			16b. Kind of Business/Industry Homemaker	
17. Father's Name (First, Middle, Last) Harmon Broadwater				18. Mother's Name (First, Middle, Maiden Surname) Mary Bittinger			
19a. Informant's Name/Relationship (Type, Print) Paul Broadwater/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2247 Aarons Run Rd. Westernport, Md 21562				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cem		Date 2/8/07	20c. Location - City or Town, State Moscow, MD	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Boal Funeral Home, 111 Church St Westernport, Md 21562				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D-14865				29d. Date signed (Month, Day, Year) FEB 5TH, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Robustiano Barrera 500 Memorial Ave. Cumberland, MD 21502							
31. Date filed (Month, Day, Year) FEB - 6 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04389

1 - For
State
Registrar

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a if show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
GERTA E. BINGHAM		February 3 2007				1115 AM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Memorial Hospital		EASTON				TALBOT	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) JULY 28, 1910	9. Birthplace (State or Foreign Country) GERMANY
Usual Residence of Decedent		10a. State MD 10b. County TALBOT 10c. City, Town or Location EASTON				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8536 AVELEY FARM ROAD		10f. Zip Code 21601				10g. Citizen of What Country? UNITED KINGDOM	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry HOMEMAKER			
17. Father's Name (First, Middle, Last) ALBERT ZUHLKE				18. Mother's Name (First, Middle, Maiden Surname) EMMA LAMPEL			
19a. Informant's Name/Relationship (Type, Print) GWENDOLIN BEYN/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8536 AVELEY FARM ROAD, EASTON, MD 21601					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR 2/5/2007		Date	20c. Location - City or Town, State STEVENSVILLE, MD		
21. Signature of Funeral Service Licensee Joseph M. Ostrowski, C.F.S.P.		22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death					
a. Pneumonia Due to (or as a consequence of):							
b. Severe malnutrition and Failure to thrive Due to (or as a consequence of):							
c. Cardiac arrhythmia Due to (or as a consequence of):							
d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D0059762		29d. Date signed (Month, Day, Year) 02/03/2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haider Sarah, MD		31. Date filed (Month, Day, Year) FEB - 5 2007 32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 390

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Sue Bennett
Baltimore, Maryland 21215-0036

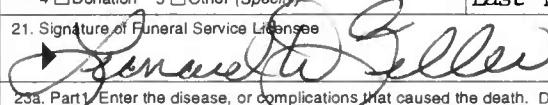
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
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Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Sue Delores Bennett		Jan 26 2007		7:20 AM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Genesis HealthCare - The Pines		Easton		Talbot
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 18, 1914
216-38-8565				9. Birthplace (State or Foreign Country) Pennsylvania
Usual Residence of Decedent				
10a. State Maryland	10b. County Talbot	10c. City, Town or Location Easton		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 610 Dutchman's Lane		10f. Zip Code 21601		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) Adam Benya			18. Mother's Name (First, Middle, Maiden Surname) Susan (Maiden Surname Unknown)	
19a. Informant's Name/Relationship (Type, Print) George Bennett/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3921 Shaker Run Circle, Fairfield, CA 94533		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) East New Market Cem.		Date 1/30/2007	20c. Location - City or Town, State East New Market, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) Pneumonia				
Approximate Interval Between Onset and Death days years				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): Advanced dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
		29c. License number D 29553	29d. Date signed (Month, Day, Year) 1-26-07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL CROWLEY MD 610 DUTCHMAN'S LANE EASTON, MD 21601				
31. Date filed (Month, Day, Year) JAN 30 2007	32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04391

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Physician /Medical Examiner		Decedent's Name (First, Middle, Last) Charles Bradley Blades								2. Date of Death Month Day Year January 27 2007		3. Time of Death 1829PM					
Funeral Director		4a. Facility Name (If not institution, give street and number) Dorchester General Hospital				4b. City, Town, or Location of Death Cambridge				4c. County of Death Dorchester							
		5. Social Security Number 219-34-3444		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs Hours Min.		8. Date of Birth (Month, Day, Year) Dec. 27, 1937		9. Birthplace (State or Foreign Country) Maryland			
		Usual Residence of Decedent															
		10a. State MD	10b. County Dorchester		10c. City, Town or Location Cambridge								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
		10e. Street and Number 1306 Colonial Avenue				10f. Zip Code 21613				10g. Citizen of What Country? USA							
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white				14. Race - American Indian, Black, White, etc.					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) licensed practical nurse				16b. Kind of Business/Industry state hospital							
		17. Father's Name (First, Middle, Last) George Nelson Blades								18. Mother's Name (First, Middle, Maiden Surname) Mary Bradley							
		19a. Informant's Name/Relationship (Type, Print) Beulah Jane Blades wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Colonial Ave., Cambridge, MD 21613											
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Birk B.				20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory				Date 1/29/07		20c. Location - City or Town, State Salisbury, MD					
		21. Signature of Funeral Service Licensee Birk B.								22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Approximate Interval Between Onset and Death 1 hour															
		b. Due to (or as a consequence of): Atherosclerotic cardiovascular disease Approximate Interval Between Onset and Death 1 month															
		c. Due to (or as a consequence of): d. Due to (or as a consequence of):															
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ischemic cardiomyopathy, hypertension chronic obstructive pulmonary disease 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier Mark Malkus, M.D.							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Malkus, M.D. 468 Burn Street Cambridge, MD 21613								29c. License number D50804							
		31. Date filed (Month, Day, Year) JAN 30 2007				32. Registrar's Signature Beulah B. Birk				29d. Date signed (Month, Day, Year) January 30, 2007							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04392

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rita A. Brown				2. Date of Death Month Day Year February 4, 2007	3. Time of Death 3:15 A M		
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center			4b. City, Town, or Location of Death Leonardtown	4c. County of Death St. Mary's			
Funeral Director	5. Social Security Number 163-05-2380	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) October 19, 1915	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent 10a. State Maryland			10b. County St. Mary's			10c. City, Town or Location Leonardtown	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 22680 Cedar Lane Court, Apt. 1219			10f. Zip Code 20650		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Electronic Manufacturer		
	17. Father's Name (First, Middle, Last) Edward Hughes			18. Mother's Name (First, Middle, Maiden Surname) Veronica Gomley				
	19a. Informant's Name/Relationship (Type, Print) Jane Saitta/ Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 686, St. Inigoes, MD 20684				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Sepulchre Cemetery		Date February 12, 2007	20c. Location - City or Town, State Cheltenham Township Montgomery County, PA		
	21. Signature of Funeral Service Licensee Michael P. Gardiner		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death minutes yrs.	
	<p>a. Due to (or as a consequence of): Acute Myocardial Infarction</p> <p>b. Due to (or as a consequence of): Coronary Artery Disease</p> <p>c. Due to (or as a consequence of): </p> <p>d. Due to (or as a consequence of): </p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 		28f. Location (Street and Number or Rural Route Number, City or Town, State) 			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 06419 / Md.		29d. Date signed (Month, Day, Year) 2-5-07			
	29b. Signature and title of certifier James P. Jarboe, M.D.		29c. License number D 06419 / Md.		29d. Date signed (Month, Day, Year) 2-5-07			
State Registrar	31. Date filed (Month, Day, Year) FEB 05 2007		32. Registrar's Signature James P. Jarboe					

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

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E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04 393

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Debora Lyn Banagan							2. Date of Death Month Day Year February 5, 2007	3. Time of Death 6:26 A M	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital			4b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 578-84-9300	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months 50	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) September 14, 1956	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Upper Marlboro								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 9015 Florin Way			10f. Zip Code 20772			10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1968 - 1972		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Human Resource Manager		16b. Kind of Business/Industry U.S. Government						
	17. Father's Name (First, Middle, Last) Joseph Ronald Banagan				18. Mother's Name (First, Middle, Maiden Surname) Jacqueline Monceaux					
	19a. Informant's Name/Relationship (Type, Print) Joseph Anthony Banagan / Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18122 Sharon Road, Ellendale, DE 19941						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Sacred Heart Cemetery	20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery			Date February 10, 2007	20c. Location - City or Town, State Bushwood, Maryland				
	21. Signature of Funeral Service Licensee Michael Gardiner		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Approximate Interval Between Onset and Death									
	23b. Part II. Enter conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Morbid Obesity									
Medical Certification: To Be Completed by Physician/Medical Examiner	23c. If female: 23b. Was decedent pregnant in the past 12 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	23f. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								23g. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier Eric McDonald, M.D.	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric McDonald, M.D. 7503 Surratts Road, Clinton, Maryland 20735								29c. License number D0064055	
State Registrar	31. Date filed (Month, Day, Year) FEB 07 2007		32. Registrar's Signature Eric McDonald							

Baltimore, Maryland 21215-0036
Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

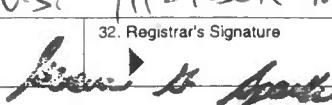
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 394

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES ANTHONY BOYLE							2. Date of Death Month FEB Day 03 Year 2007		3. Time of Death 7:55 PM
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE			4c. County of Death		
Funeral Director	5. Social Security Number 216-42-0706		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 61	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) AUG. 4, 1945	9. Birthplace (State or Foreign Country) MARYLAND		
	10a. State MD		10b. County ST. MARY'S		10c. City, Town or Location ABELL			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 38800 CHASKO ROAD				10f. Zip Code 20606			10g. Citizen of What Country? U. S. A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES REPRESENTATIVE			16b. Kind of Business/Industry CUSTOM HOMES			
17. Father's Name (First, Middle, Last) (UNAVAILABLE)				18. Mother's Name (First, Middle, Maiden Surname) (UNAVAILABLE)						
19a. Informant's Name/Relationship (Type, Print) STEPHANIE L. BOYLE / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38800 CHASKO ROAD ABELL, MARYLAND 20622						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BRINSFIELD-ECHOES CR.		20b. Place of Disposition (Name of cemetery, crematory or other place) BRINSFIELD-ECHOES CR.		Date FEB. 8, 2007	20c. Location - City or Town, State CHARLOTTE HALL, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility BRINSFIELD-ECHOES FUNL.HME., P.A.						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CANCER				Approximate Interval Between Onset and Death 5 MONTHS						
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		26. Place of Death (Check only one)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 80060105			29d. Date signed (Month, Day, Year) FEB 6 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN QUEST-THERSENE MJS 900 SCATON AVENUE BALTIMORE MD		31. Date filed (Month, Day, Year) FEB 08 2007			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

James Boyle
Within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04395

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gloria Alma Bruns					2. Date of Death Month Day Year February 7, 2007	3. Time of Death 4:05 A M
	4a. Facility Name (If not institution, give street and number) 23140 Cobblestone Lane Apt. 309			4b. City, Town, or Location of Death California		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 219-20-2407	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) June 7, 1926	9. Birthplace (State or Foreign Country) Brunswick, MD
	Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's 10c. City, Town or Location California						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 23140 Cobblestone Lane Apt. 309			10f. Zip Code 20619		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Shipping Officer		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health Care/Research		16b. Kind of Business/Industry Health Care/Research	
	17. Father's Name (First, Middle, Last) Robert Raymond Riser			18. Mother's Name (First, Middle, Maiden Surname) Grace Estelle Athey			
	19a. Informant's Name/Relationship (Type, Print) Leslie Ann McCasker/ Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39062 Ash George Road, Lovettsville, VA 20180			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metropolitan Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place)	Date February 9, 2007	20c. Location - City or Town, State Alexandria, VA	
	21. Signature of Funeral Service Licensee <i>Michael Kevin Hardin</i>			22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BRAIN METASTASIS			Approximate Interval Between Onset and Death YEAR.			
	a. Due to (or as a consequence of): BREAST CANCER						
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
	d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			
	23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D56096			29d. Date signed (Month, Day, Year) 2-7-07
	29b. Signature and title of certifier <i>R. S. Gill</i>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RASBINDER S. GILL SHAH ASSOCIATES, HOLLYWOOD, MD 20836						
State Registrar	31. Date filed (Month, Day, Year) FEB 09 2007			32. Registrar's Signature <i>Rasbinder S. Gill</i>			

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04396

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
AGNES CECILIA BECKWITH		JAN. 27, 2007		8:02 A M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
ALLEGANY COUNTY NURSING HOME		CUMBERLAND		ALLEGANY
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 103 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) APR. 4, 1903
218-24-7831				9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent				
10a. State MD	10b. County ALLEGANY	10c. City, Town or Location FLINTSTONE		
10e. Street and Number 13101 BLUEGRASS DRIVE			10f. Zip Code 21530	10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOMEMAKER		
17. Father's Name (First, Middle, Last) HENRY JOSEPH SHAVER			18. Mother's Name (First, Middle, Maiden Surname) MARY NAU	
19a. Informant's Name/Relationship (Type, Print) DEBORAH DEREMER/GRANDDAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 161, FLINTSTONE, MD 21530		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) PINE VIEW MEML. PARK	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 02/01/2007		20c. Location - City or Town, State WARREN, OH
21. Signature of Funeral Service Licensee Henry J. Lechner				
22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Approximate Interval Between Onset and Death 7 yr				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Robertano J. Barrera, Jr., M.D.		29c. License number D-14865		29d. Date signed (Month, Day, Year) JAN 27th, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robertano J. Barrera, Jr., M.D. -500 Memoria Ave, Cumberland, MD 21502				
31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature R. A. Parker		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04397

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Debra Ann Bratt					2. Date of Death Month January Day 29, Year 2007	3. Time of Death 0950 M	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 233-06-0713	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 05/31/1959	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State WV 10b. County Mineral 10c. City, Town or Location Ridgeley					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 37 Washington Street			10f. Zip Code 26753		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	Lab Tech			16b. Kind of Business/Industry Health System		
	17. Father's Name (First, Middle, Last) Arthur William Bratt, III			18. Mother's Name (First, Middle, Maiden Surname) Shirley Louise Clites				
	19a. Informant's Name/Relationship (Type, Print) Arthur W. Bratt, III / father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 922, Ridgeley, West Virginia 26753				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		Date 01/31/2007	20c. Location - City or Town, State Cumberland, MD	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. Morbid Obesity Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 10 days 10 years							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 25406					
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) January 30, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Lamm, M.D., 900 Seton Drive, Cumberland, MD 21502							
	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04398

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

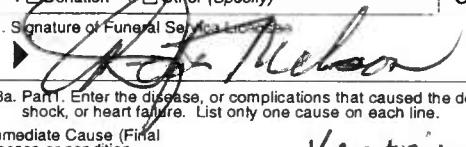
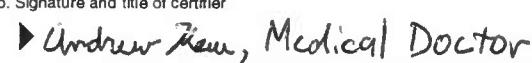
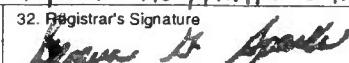
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Robert Blackard		January 29 2007		07:15 AM
4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death BALTIMORE
5. Social Security Number 214-86-3943		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	8. Date of Birth (Month, Day, Year) 4-23-1966
9. Birthplace (State or Foreign Country) MARYLAND				
10a. State DELAWARE		10b. County SUSSEX		10c. City, Town or Location DAGSBORO
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 135 RIVERVIEW DRIVE		10f. Zip Code 19939		10g. Citizen of What Country? US
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) NONE		16b. Kind of Business/Industry NONE
17. Father's Name (First, Middle, Last) RICHARD BLACKARD		18. Mother's Name (First, Middle, Maiden Surname) BEULAH COLLINS		
19a. Informant's Name/Relationship (Type, Print) BEULAH GARUFI / MOTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 RIVERVIEW DRIVE, DAGSBORO, DE. 19939		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) GATE OF HEAVEN CEMETERY		Date 2-2-07
21. Signature of Funeral Service Licensee 		20c. Location - City or Town, State MELSON FUNERAL SERVICES, LTD. THATCHER ST, FRANKFORD, DE. 19945		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 3 months		
a. Ventricular Tachycardia, Recurrent Due to (or as a consequence of):				
b. Hypertrophic cardiomyopathy Due to (or as a consequence of):		5 years		
c. End Stage Renal Disease Due to (or as a consequence of):		10 years		
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
29c. License number Res-000		29d. Date signed (Month, Day, Year) January 29, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kau, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287		Baltimore, Maryland 21287		
31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04399

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year	3. Time of Death	
	LEE ANN BLAKE					February 7, 2007	6:35 P M	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
	Greater Baltimore Medical Center			Towson			Baltimore	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/22/1955	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent			10a. State MD. 10b. County Harford 10c. City, Town or Location Forest Hill			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	10e. Street and Number 3342 Kreitler Road			10f. Zip Code 21050			10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 0 Clerk			16b. Kind of Business/Industry Harford County Government	
	17. Father's Name (First, Middle, Last) William Burton Watkins			18. Mother's Name (First, Middle, Maiden Surname) Doris Jean Walker				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Darrell J. Blake/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3342 Kreitler Rd. Forest Hill, Md. 21050				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Carroll Cremation			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date 2/14/2007	20c. Location - City or Town, State Hampstead, Maryland
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee M. Gladden Kurtz			22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A.				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9 Unknown			23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? Anemia Renal Insufficiency						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D-44728			29d. Date signed (Month, Day, Year) 02-08-2007	
	29b. Signature and title of certifier Mitchell Schuyler MD			32. Registrar's Signature Anne B. Schuyler				
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 2a) (Type, Print) Mitchell Schuyler MD 6535 N. Charles St. Ste 601 Towson, MD 21204			31. Date filed (Month, Day, Year) FEB 14 2007				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 04400

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALLIE LORETTA BAUMGARDNER					2. Date of Death Month FEBRUARY Day 7 , Year 2007	3. Time of Death 10:14A M	
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL			4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 214-28-2316	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) Mar 30, 1931	9. Birthplace (State or Foreign Country) Kentucky	
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 30 North Place			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Buck Tracey			18. Mother's Name (First, Middle, Maiden Surname) Elsie Spurlock				
	19a. Informant's Name/Relationship (Type, Print) Jerry Cleaver, Sr, Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 377 West Thornhill Pl, Frederick, Maryland 21703				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Market Cemetery		Date Feb 10, 2007	20c. Location - City or Town, State New Market, Maryland		
	21. Signature of Funeral Service Licensee <i>Rhonda Roseau</i>		22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 21701					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypoxemia Due to (or as a consequence of): Diabetes Mellitus Hypertension Coronary artery disease Approximate Interval Between Onset and Death Days Days Hours							
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Hypertension Coronary artery disease							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Praveen Bolakun, MD</i>							
	29c. License number DO062223							
	29d. Date signed (Month, Day, Year) 2/7/07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Praveen Bolakun, MD, 400 West Seventh Street, Frederick, Maryland 21701							
State Registrar	31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature <i>Steve B. Spurlock</i>					

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

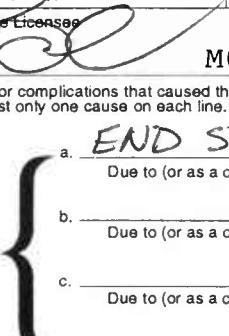
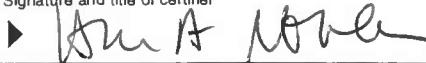
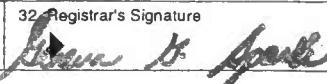
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04401

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN BARBER							2. Date of Death Month Day Year FEBRUARY 8 2007	3. Time of Death 6:35 p ^M		
	4a. Facility Name (If not institution, give street and number) Chestertown Nursing & Rehab			4b. City, Town, or Location of Death Chestertown			4c. County of Death Kent				
Funeral Director	5. Social Security Number 074-30-4124		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Mar 17 1910	9. Birthplace (State or Foreign Country) New York			
	Usual Residence of Decedent		10a. State FL. 10b. County Broward			10c. City, Town or Location Pembroke Pines			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 9811 N. Hollybrook Lake Dr.				10f. Zip Code 33025			10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Interior Designer			16b. Kind of Business/Industry Self-employed				
	17. Father's Name (First, Middle, Last) Raphael Pecker				18. Mother's Name (First, Middle, Maiden Surname) Rachel Hendelman						
	19a. Informant's Name/Relationship (Type, Print) Bonnie Fisher (daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Bohemia Lane Earleville, MD. 21919							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kent Cremation			Date 2/9/07	20c. Location - City or Town, State Smyrna, DE.				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE DEMENTIA								Approximate Interval Between Onset and Death 75 years		
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29b. Signature and title of certifier 		29c. License number D0041587						29d. Date signed (Month, Day, Year) 2/9/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, M.D. 122 Speer Rd. Chestertown, MD. 21620										
State Registrar	31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature 						ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 04402
Reg. No.1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anne V. Como	Jan. 29, 2007	1815 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shady Grove Adventist	Rockville	Montgomery

5. Social Security Number	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 2/04/1930	9. Birthplace (State or Foreign Country) Pennsylvania
168-22-0957					

10a. State MD	10b. County Montgomery	10c. City, Town or Location Damascus	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

10e. Street and Number 10001 Biscayne Lane	10f. Zip Code 20872	10g. Citizen of What Country? USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2 Accountant	16b. Kind of Business/Industry Restaurant

17. Father's Name (First, Middle, Last) John Metil	18. Mother's Name (First, Middle, Maiden Surname) Anna Chockota

19a. Informant's Name/Relationship (Type, Print) Lynn Como/Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10001 Biscayne Lane Damascus, Maryland 20872

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Twin Valley Mem. Pk	20b. Place of Disposition (Name of cemetery, crematory or other place) Twin Valley Mem. Pk	Date 2/02/2007	20c. Location - City or Town, State Delmont, Pa.

21. Signature of Funeral Service Licensee ▶ Philip D. Rinaldi	22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death days

23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Sept SIS</i> Due to (or as a consequence of):	clostridium difficile colitis days
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year) M	28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28c. Injury at Work? 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

29b. Signature and title of certifier ▶ Alicia T. Mistry MD	29c. License number D59738	29d. Date signed (Month, Day, Year) January 30, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alicia T. Mistry 9901 Medical Center Drive Rockville, MD 20850

31. Date filed (Month, Day, Year) JAN 31 2007	32. Registrar's Signature ▶ Alicia T. Mistry

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04403

1- For
State
Registrar

Reg. No.

**Physician
/Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

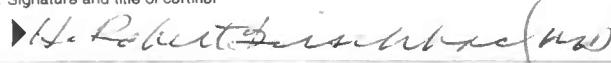
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner shall be notified at once.

**Physician
/Medical
Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Nancy Carey		January 28, 2007		6:00 A.M.
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Wilson Health Care Center		Gaithersburg		Montgomery
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	II Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 13, 1925
032-18-9190				9. Birthplace (State or Foreign Country) MA.
Usual Residence of Decedent				
10a. State	10b. County	10c. City, Town or Location Washington, DC.		
		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3220 Connecticut Ave., N.W.		10f. Zip Code 20008		10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Publications Clerk		
		16b. Kind of Business/Industry Brookings Institution		
17. Father's Name (First, Middle, Last) Thomas J. Carey		18. Mother's Name (First, Middle, Maiden Surname) Kathryn Wilson		
19a. Informant's Name/Relationship (Type, Print) Kathleen A. Epps/Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20325 Cedarhurst Way, Germantown, Maryland 20876		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 1/30/2007 Alexandria, Virginia
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <i>Hepatic failure</i> Due to (or as a consequence of):</p> <p>b. <i>Metastatic liver disease</i> Due to (or as a consequence of):</p> <p>c. <i>Carcinoma of breast</i> Due to (or as a consequence of):</p> <p>d.</p>				
Approximate Interval Between Onset and Death One month				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, Severe debilitus</i> <i>Anemia of chronic disease</i> <i>Chronic obstructive pulmonary disease</i>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  29c. License number 004115		
		29d. Date signed (Month, Day, Year) January 28, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. ROBERT BIRCHBACH, M.D.		31. Date filed (Month, Day, Year) JAN 31 2007		
		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04404

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Benedict Caccia
Baltimore, Maryland 21215-0036
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Jan Day 30 Year 2007		3. Time of Death 9:22 AM
BENEDICT A. CACCIA				
4a. Facility Name (If not institution, give street and number) Genesis HealthCare - The Pines		4b. City, Town, or Location of Death Easton		4c. County of Death Talbot
5. Social Security Number 107-22-3707	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON
10e. Street and Number 28310 CANVASBACK LANE		10f. Zip Code 21601		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
				14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 ADMINISTRATION		16b. Kind of Business/Industry INTERNATIONAL BUSINESS MACHINES
17. Father's Name (First, Middle, Last) VINCENT CACCIA		18. Mother's Name (First, Middle, Maiden Surname) VICTORIA SALERNO		
19a. Informant's Name/Relationship (Type, Print) NATALIE CACCIA/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28310 CANVASBACK LANE, EASTON, MD 21601		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR		Date 2/6/2007
21. Signature of Funeral Service Licensee <i>Joseph J. Ostrowski C.F.S.P.</i>		22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601		20c. Location - City or Town, State STEVENSVILLE, MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Non-small cell lung carcinoma</i>		Approximate Interval Between Onset and Death <i>years</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):		
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
23f. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number DZ5933		29d. Date signed (Month, Day, Year) 1-30-07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL CROWLEY, MD 610 DUTCHMAN'S LANE EASTON, MD 21601		32. Registrar's Signature 		
31. Date filed (Month, Day, Year) FEB - 2 2007				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04405

For
State
Registrar

**Physician
/Medical
Examiner**

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

**Physician
/Medical
Examiner**

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) DENNIS CARPENTER		2. Date of Death Month 01 Day 22 Year 2007	3. Time of Death 6:50 A. M
4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS		4b. City, Town, or Location of Death CUMBERLAND	
4c. County of Death ALLEGANY		4d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
5. Social Security Number 220-58-0343		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.
8. If Under 1 Year Months 0 Days 0		9. If Under 24 Hrs. Hours 0 Min. 0	
10. City, Town or Location RIDGELEY		11. Date of Birth (Month, Day, Year) AUG. 23, 1951	
12. Usual Residence of Decedent 10a. State WV 10b. County MINERAL		13. Birthplace (State or Foreign Country) MARYLAND	
14. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		15. Citizen of What Country? U.S.A.	
16. Street and Number ROUTE 28		17. Zip Code 26753	
18. Father's Name (First, Middle, Last) LEE EUGENE CARPENTER, JR.		19. Mother's Name (First, Middle, Maiden Surname) AUDREY MILDRED EVERETT	
20. Informant's Name/Relationship (Type, Print) RHODA CARPENTER / WIFE		21. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) CUMBERLAND CREMATORI	
22. Place of Disposition (Name of cemetery, crematory or other place) UPCHURCH FUNERAL HOME, P.A.		Date 01/24/2007	23. Location - City or Town, State CUMBERLAND, MD
24. Signature of Funeral Service Licensee Henry A. Yockewill		25. Approximate Interval Between Onset and Death	
26. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Massive Acute Myocardial Infarction			
27. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
28. Due to (or as a consequence of): a. Massive Acute Myocardial Infarction b. _____ c. _____ d. _____			
29. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		30. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
31. Date of delivery Month Day Year		32. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
33. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		34. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
35. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		36. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
37. Date of Injury (Month, Day Year)		38. Time of Injury M	
39. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		40. Describe how injury occurred	
41. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		42. Location (Street and Number or Rural Route Number, City or Town, State)	
43. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		44. License number D0064167	
45. Signature and title of certifier N. Qaisrani MD		46. Date signed (Month, Day, Year) 1/23/07	
47. Name and address of person who completed cause of death (Item 23a) (Type, Print) Noshin Qaisrani M.D. 500 Memorial Avenue, Cumberland, MD 21502		48. Date filed (Month, Day, Year) JAN 25 2007	
49. Registrar's Signature [Signature]		50. Date signed (Month, Day, Year) 1/23/07	

Amended #23b, nls,
01/29/07, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 011406

1 - State
Registrar

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year				3. Time of Death			
CHARLES CLIFFORD COFIELD							JANUARY 28, 2007				12:46 A.M.			
4a. Facility Name (If not institution, give street and number) Memorial Hospital							4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany			
5. Social Security Number 220-36-4058		6. Sex M		7. Age (In yrs. last birthday) 63			If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 03/30/1943		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent		10a. State MD		10b. County Allegany			10c. City, Town or Location Cumberland						10d. Inside City Limits Yes	
10e. Street and Number 112 Memorial Avenue, Apt 15F							10f. Zip Code 21502				10g. Citizen of What Country? USA			
11. Marital Status Never Married			12. Was Decedent Ever in U.S. Armed Forces? Yes			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) No			14. Race - American Indian, Black, White, etc. Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Union								
17. Father's Name (First, Middle, Last) Rogers E. Cofield							18. Mother's Name (First, Middle, Maiden Surname) Emma James							
19a. Informant's Name/Relationship (Type, Print) Lianne Cofield / wife							19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Memorial Avenue, Apt 15F, Cumberland, MD 21502							
20a. Method of Disposition Burial							20b. Place of Disposition (Name of cemetery, crematory or other place) Davis Memorial Cem.			Date 02/01/2007		20c. Location - City or Town, State Cumberland, MD		
21. Signature of Funeral Service Licensee Robert C. Adams							22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502							

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death							
a. Ruptured abdominal aortic aneurysm Due to (or as a consequence of):							12 hours							
b. Arthrosclerosis Due to (or as a consequence of):							10 years							
c. _____ Due to (or as a consequence of):														
d. _____ Due to (or as a consequence of):														
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes							23c. If yes, outcome pf pregnancy Live birth					23d. Date of delivery Month Day Year		
							3 Ectopic pregnancy							
							4 Pregnant at time of death							
							5 Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
Hypertension														
Diabetes														
25. Was case referred to medical examiner? Yes							26. Place of Death (Check only one) Hospital: Inpatient					Other: Nursing Home		
							ER/Outpatient					Residence		
							DOA					Other (Specify)		
27. Manner of Death Natural							28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred	
									M		1 Yes 2 No			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)							

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier R. D. Chisholm, MD							29c. License number D34362		29d. Date signed (Month, Day, Year) January 28, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Roy Chisholm, 924 Seton Drive, Cumberland, Md 21502							31. Date filed (Month, Day, Year) JAN 29 2007				
							32. Registrar's Signature R. D. Chisholm				

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04407

1- For State Registrar

Physician/ Medical Examiner 9349	1. Decedent's Name (First, Middle, Last) Inocencio Orzuna Casasola				2. Date of Death Month Day Year February 7, 2007	3. Time of Death 0600 hrs		
	4a. Facility Name (if not institution, give street and number) 19943 Spur Hill Road		4b. City, Town, or Location of Death Montgomery Village		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number none	6. Sex 1 XM 2 F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (MM/DD/YYYY) June 22, 1971	9. Birthplace (State or Foreign Country) Mexico	
	10a. State Md		10b. County Montgomery		10c. City, Town or Location Montgomery Village		10d. Inside City Limits 1 Yes 2 No	
To Be Completed by Funeral Director	10e. Street and Number 19943 Spur Hill Road			10f. Zip Code 20886		10g. Citizen of What Country? Mexico		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No specify: Mexican		14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Electric Co.			
	17. Father's Name (First, Middle, Last) Emilio Orzuna			18. Mother's Name (First, Middle, Maiden Surname) Teresa Casasola				
	19a. Informant's Name/Relationship (Type, Print) Angel Casasola/Cousin			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5309 Riverdale Rd. Riverdale, Maryland 20737				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Nelly Orzuna</i>		20b. Place of Disposition (Name of cemetery, cemetery (if applicable)) Cementerio de Tronconal, Mexico		Date 2/16/07	20c. Location - City or Town, State Tronconal, Mexico		
	21. Signature of Funeral Service Licensee <i>Nelly Orzuna</i>			22. Name and Address of Facility PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd Silver Spring Md 20910				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute alcohol intoxication Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input checked="" type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED #1,23a,27,28a-f, perME, g864, 2/21/07 TT							
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene							
	26. Place of Death (Check only one)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day, Year) Fnd 2/7/2007		28b. Time of Injury Fnd 6:00 am		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found Townhouse/ rowhouse							
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 19943 Spur Hill Rd. Montgomery Village, MD							
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Carol Allan</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 8, 2007	
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
State Registrar	31. Date filed (Month Day Year) FEB 12 2007		32. Registrar's Signature <i>James B. Jones</i>		33.			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 08

Reg. No.

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		RUTH NAOMI CROWL				2. Date of Death Month Day Year	3. Time of Death M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death Taneytown				4c. County of Death Carroll County	
5. Social Security Number 214-14-6561		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) June 24, 1915	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent Maryland Carroll County		10c. City, Town or Location Taneytown				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2600 Crouse Mill Road		10f. Zip Code 21787				10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) factory worker		16b. Kind of Business/Industry garment manufacture			
17. Father's Name (First, Middle, Last) William J. Eckard		18. Mother's Name (First, Middle, Maiden Surname) Laura Kate Lippy					
19a. Informant's Name/Relationship (Type, Print) Charles W. Crowl, Jr. / son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Crouse Mill Road Taneytown, Maryland 21787				Date Feb. 10 2007	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) John Luther Miller Memorial Cemetery		20c. Location - City or Town, State Westminster, Maryland			
21. Signature of Funeral Service Licensee Stan C. Purvis		22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of): Searvi</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced age							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) 2-7-07	
29b. Signature and title of certifier Jason A. Tate, M.D.		29c. License number D 43643					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason A. Tate, M.D. 1 Kings Drive Taneytown, Maryland 21787							
31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature Laura S. Apelle					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04409

1 - For State Registrar

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death				3. Time of Death		
DOROTHY MAE CARROLL		Month	Day	Year	4:45 A M		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
Gilchrist Hospice Center		Towson			Baltimore		
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)		
220-07-7254	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	86 Yrs.	Months	Days	Hours Min.	11/22/1920	9. Birthplace (State or Foreign Country)
Usual Residence of Decedent		10d. Inside City Limits					
10a. State	10b. County	10c. City, Town or Location					
MD.	Harford	Jarrettsville				1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?		
3203 Melde Court			21084		United States		
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: White	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
Elementary/Secondary (0-12) 12	College (1-4 or 5+) 1	Secretary			Catholic School		
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)				
Bernard			Jacobs			Theresa	Stallings
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Regina M. Ponton/Daughter			3203 Melde Ct. Jarrettsville, Md. 21084			Date	20c. Location - City or Town, State
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) M. Blakken Kurtz		Gardens of Faith			2/12/2007 Rosedale, Maryland		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
M. Blakken Kurtz		Jarrettsville, Maryland			E.G. Kurtz & Son Funeral Home, P.A.		Years
23a. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of):					
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Due to (or as a consequence of):					
23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23f. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospital			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier W.A. Riley G.Bmc		29c. License number 025205			29d. Date signed (Month, Day, Year) February 7, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley G.Bmc 6701 N. Charles St. Balt. md 21204							
31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature James B. Appler					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04410

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Grant Dixon						2. Date of Death Month Feb 4 Year 2007	3. Time of Death 7:10 am	
Funeral Director	4a Facility Name (If not institution, give street and number) 4674 Sang Run Rd.				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett		
To Be Completed by Funeral Director	5. Social Security Number 212 12 9792	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept 4, 1918	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State MD						10b. County Garrett	10c. City, Town or Location Oakland	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 4674 Sang Run Rd.			10f. Zip Code 21550			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates: 8			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer USDA Poultry Inspector			16b. Kind of Business/Industry Poultry		
	17. Father's Name (First, Middle, Last) Edwin Dixon						18. Mother's Name (First, Middle, Maiden Surname) Bertha L. Fike		
	19a. Informant's Name/Relationship (Type, Print) Maude Dixon, Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4674 Sang Run Rd., Oakland, MD 21550		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Blooming Rose Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Blooming Rose Cemetery			Date 2/7/07	20c. Location - City or Town, State Friendsville, MD	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee David R. Burdock						22. Name and Address of Facility Burdock-Durst Funeral Home 21 N. Second St., Oakland, MD 21550		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death Hours		
	a. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Atherosclerotic Cardiovascular Dis								
	b. { Due to (or as a consequence of): Years.								
	c. Due to (or as a consequence of): Years.								
	d. Due to (or as a consequence of): Years.								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) 2/5/07		
	29b. Signature and title of certifier Robert A. Goralski						29c. License number D23797		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert A. Goralski, MD 311 N. Fourth St., Oakland, MD 21550								
State Registrar	31. Date filed (Month, Day, Year) FEB - 5 2007			32. Registrer's Signature					

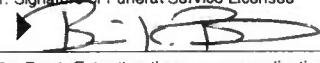
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert Raphael Dodson, Sr.						2. Date of Death Month Day Year January 27, 2007	3. Time of Death 15:55P		
	4a. Facility Name (If not institution, give street and number) 5020 Bucktown Road			4b. City, Town, or Location of Death Cambridge			4c. County of Death Dorchester			
Funeral Director	5. Social Security Number 214-07-8571	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 94 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 20, 1912	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10a. State MD 10b. County Dorchester 10c. City, Town or Location Cambridge						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 5020 Bucktown Road			10f. Zip Code 21613			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white	14. Race - American Indian, Black, White, etc. Specify:				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanic			16b. Kind of Business/Industry city government			
	17. Father's Name (First, Middle, Last) John Thomas Dodson				18. Mother's Name (First, Middle, Maiden Surname) Pearl Vane					
	19a. Informant's Name/Relationship (Type, Print) Jane Brown daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5020 Bucktown Road, Cambridge, MD 21613						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park		Date 1/30/07	20c. Location - City or Town, State Cambridge, MD				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613						
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	a. Arteriosclerotic Heart Disease Due to (or as a consequence of): Advance Dementia									
	b. Due to (or as a consequence of): 									
	c. Due to (or as a consequence of): 									
	d. 									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input checked="" type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 Natural <input type="checkbox"/> Pending <input type="checkbox"/> Accident investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be <input type="checkbox"/> Homicide determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D 47924			29d. Date signed (Month, Day, Year) 1-29-07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORMAN THANHNY 300 AURORA ST CAMBRIDGE MD 21613									
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04412

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death		
	Frank Samuel Dove, Sr.				February 1, 2007	8:04 A M		
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death		
	Southern Maryland Hospital Center			Clinton		Prince George		
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 552-48-7580 72	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 07/15/1934	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent	10a. State Maryland 10b. County Prince George 10c. City, Town or Location Camp Springs				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 5003 Silver Valley Way	10f. Zip Code 20746			10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Transportation	16b. Kind of Business/Industry Civil Service					
	17. Father's Name (First, Middle, Last) Joseph Thomas Dove	18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Cutchember						
	19a. Informant's Name/Relationship (Type, Print) Francine D. Hawkins/ Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20296 Poplar Ridge Road, Lexington Park, MD 20653						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) St. Luke's Meth. Cem.	Date 02/10/2007	20c. Location - City or Town, State Scotland, Maryland				
	21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052	22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<i>Myocardial infarction</i>					Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Obafemi Opesanmi</i>	29c. License number DD 46303			29d. Date signed (Month, Day, Year) 2/1/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opesanmi, Obafemi, M.D., 7503 Surratts Road, Clinton, Maryland 20735							
State Registrar	31. Date filed (Month, Day, Year) FEB 05 2007	32. Registrar's Signature <i>John S. Apak</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04413
Reg. No.1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Richard James Davis</i>		01 27 07		11:40 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Oakland Nursing + Rehab</i>		<i>705 E. Alde St., Oakland</i>		<i>Garrett</i>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>54</i> Yrs.	If Under 1 Year Months Days Hours Min.
<i>214-62-3859</i>				
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		
<i>11 02 1952</i>		<i>Louisiana</i>		
10a. State <i>MD</i>		10b. County <i>Allegany</i>	10c. City, Town or Location <i>Frostburg</i>	
			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>57 Meshach Frostburg Village</i>		10f. Zip Code <i>21532</i>		10g. Citizen of What Country? <i>U.S.A.</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Tractor Trailer Driver</i>		16b. Kind of Business/Industry <i>Truck Driver</i>
17. Father's Name (First, Middle, Last) <i>John Davis</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Betty, Page</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Paul Davis Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>15385 Cobble Drive Greencastle PA 17225</i>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>21532</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Frostburg Memorial Park</i>		20c. Location - City or Town, State <i>01-31-2007 Frostburg MD</i>
21. Signature of Funeral Service Licensee <i>John R. Garrett</i>		22. Name and Address of Facility <i>Durst Funeral Home, 57 Frost Ave. Frostburg MD</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Endstage Parkinson's Disease</i> Approximate Interval Between Onset and Death <i>Years</i>		
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) <i>Unknown</i>		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>H26154</i>		29d. Date signed (Month, Day, Year) <i>01-28-07</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul Daniel Miller D.O. 69 Wolf Acres Drive Oakland MD 21550</i>				
31. Date filed (Month, Day, Year) <i>JAN 30 2007</i>		32. Registrar's Signature <i>[Signature]</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007

ALL 14

1 - For State Registrar		AMEND#17, 18perH2/1/07, BMW, MCo		2. Date of Death Month Day Year	3. Time of Death	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELISE M. DAVIS			4c. County of Death PRINCE GEORGES		
Funeral Director	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL		4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES	
To Be Completed by Funeral Director	5. Social Security Number 264-36-9554	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 76	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 14, 1931	
	Usual Residence of Decedent 10a. State MD. 10b. County PRINCE GEORGES		10c. City, Town or Location LANHAM		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 9885 GREENBELT RD.		10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: NO	14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RECEPTIONIST		16b. Kind of Business/Industry HOSPITAL	
	17. Father's Name (First, Middle, Last) Johnnie JOHN ALDERMAN		18. Mother's Name (First, Middle, Maiden Surname) HATTIE Seals		UNK	
	19a. Informant's Name/Relationship (Type, Print) DREXEL DAVIS/SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 GUMWOOD DR., HYATTSVILLE, MD. 20783			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) CHAMBERS CREMATORY		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY	Date 2-1-2007	20c. Location - City or Town, State RIVERDALE, MD.	
	21. Signature of Funeral Service Licensee W.W. Chambers		22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MARYLAND 20737			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DYSRHYTHMIA					Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of): VASCULAR DISEASE					
	c. Due to (or as a consequence of):					
	d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DIABETES HYPERTENSION					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28/01/07	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) Shobhit Arora, MD, 575 Main St., Suite 351, Laurel, MD. 20707			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number MDD 54675		29d. Date signed (Month, Day, Year) 1/31/07	
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature Shobhit Arora			

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 04415
Reg. No.1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)

Mason W. Duncan2. Date of Death
Month Day Year
FEBRUARY 6 20073. Time of Death
6:37 A.M.

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

215-58-3834

6. Sex

 M F

7. Age (In yrs. last birthday)

88

Yrs.

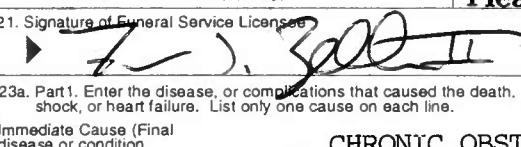
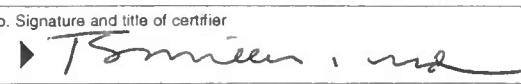
If Under 1 Year
MonthsIf Under 24 Hrs.
Days

Hours

Min.

8. Date of Birth
(Month, Day, Year)**Aug. 19, 1919**

9. Birthplace (State or Foreign Country)

TennesseeUsual Residence of Decedent
10a. State **Maryland** 10b. County **Harford** 10c. City, Town or Location **Darlington**
10e. Street and Number **4157 Flintville Rd.** 10f. Zip Code **21034** 10g. Citizen of What Country? **U.S.A.**
11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: **41-42**
13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc.
Specify: **White**
15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) **12** College (1-4 or 5+)
16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Seaman U.S. Navy 16b. Kind of Business/Industry
Government
17. Father's Name (First, Middle, Last)
Jacob Duncan 18. Mother's Name (First, Middle, Maiden Surname)
Novella Martin
19a. Informant's Name/Relationship (Type, Print)
Jack Koennerker Brother-in-Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15051 West Hickory Ct. Surprise, Arizona 85374
20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Hill Cem. Date **2/13/2007** 20c. Location - City or Town, State
Clinton, TN
21. Signature of Funeral Service Licensee
 22. Name and Address of Facility
Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Approximate Interval Between Onset and Death
UNKNOWN
a. **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
Due to (or as a consequence of):
b. _____
c. _____
d. _____
IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) _____
23d. Date of delivery
Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown
HYPERTENSION · HYPOTHYROIDISM
23f. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No
25. Was case referred to medical examiner?
1 Yes 2 No
26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier
(Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier

29c. License number
D30272 29d. Date signed (Month, Day, Year)
FEBRUARY 6, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS MILLER, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902
31. Date filed (Month, Day, Year)
FEB 15 2007 32. Registrar's Signature

State Registrar
DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN BY PHYSICIAN: DUNCAN, MASON W.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, Medical Examiner must be notified at once.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04416

1- For
State
RegistrarPhysician
/Medical
Examiner

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1-

Funeral
Director

To Be Completed by Physician/Medical Examiner

1-

For
State
Registrar

1-

For
State
Registrar

1. Decedent's Name (First, Middle, Last) MARGARET ETHEL DRINKS				2. Date of Death Month Day Year January 29 2007 6:38 PM	3. Time of Death
4a. Facility Name (If not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death La Plata	4c. County of Death Charles
5. Social Security Number 579-01-7053		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) APR. 21, 1914	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent 10a. State MARYLAND 10b. County CHARLES 10c. City, Town or Location LA PLATA 10d. Inside City Limits XX Yes 2 No					
10e. Street and Number #1 MAGNOLIA DRIVE			10f. Zip Code 20646		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) JOHN MARSHALL HUNTINGTON				18. Mother's Name (First, Middle, Maiden Surname) DELLA M. HILL	
19a. Informant's Name/Relationship (Type, Print) MARGARET BOGGS-DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1363 REDWOOD CIRCLE, LA PLATA, MD 20646		
20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. IGNATIUS CH. CEM.		Date 2-5-07	20c. Location - City or Town, State CHAPEL PT., MD
21. Signature of Funeral Service Licensee Margaret Boggs-Daughter					
22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. Due to (or as a consequence of): ADVANCED ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, 2 years.</p> <p>b. Due to (or as a consequence of): ADVANCED RHEUMATOID ARTHRITIS, 2 years.</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		24a. Was an autopsy performed? 1 Yes 2 No	
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) George H. Watson MD, FACP		29b. Signature and title of certifier George H. Watson MD, FACP		29c. License number D.20629	29d. Date signed (Month, Day, Year) 11 30 07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George H. Watson MD, FACP 11345 Pembroke Sq Waldorf, Md. 20603 Suite 103					
31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature George H. Watson			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04417

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Howard Denison

Division or Vital Records, P.O. Box 68760,

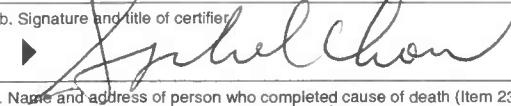
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
HOWARD DOAN DENISON, JR.		January 27 07		11:55a M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Civista Medical Center Laplata		Laplata		Charles	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 17, 1913	9. Birthplace (State or Foreign Country) WEST VIRGINIA
Usual Residence of Decedent		10a. State MARYLAND		10b. County CHARLES	
10c. City, Town or Location WHITE PLAINS		10f. Zip Code 20695		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-1956		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHEIF MASTER DIVER		16b. Kind of Business/Industry U.S. NAVY	
17. Father's Name (First, Middle, Last) HOWARD D. DENISON		18. Mother's Name (First, Middle, Maiden Surname) ICIE V. LITTLE			
19a. Informant's Name/Relationship (Type, Print) ROBERT D. DENISON-SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5870 RIPLEY PARK DR., LA PLATA, MD 20646			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERAN'S CEM. 2-2-07		Date	20c. Location - City or Town, State CHELTENHAM, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac, respiratory, etc. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Congestive Heart Failure		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): Intracranial hemorrhage			
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29d. Date signed (Month, Day, Year) 1/27/07	
29b. Signature and title of certifier 		29c. License number D-37174			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Song Chon MD, Cenna Medical Center, 7C Post Office Rd, MD 20602					
31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

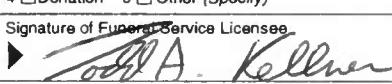
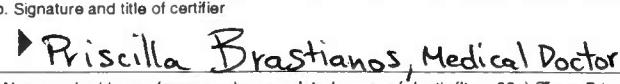
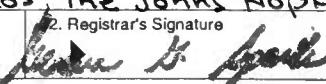
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04418

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Melissa Frainie							2. Date of Death Month Day Year February 12 2007	3. Time of Death 20:23 M		
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City			4c. County of Death N/A				
Funeral Director	5. Social Security Number 219-19-2937	6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec 12, 1971	9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent			10a. State MD 10b. County Baltimore 10c. City, Town or Location Reisterstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 7 Greenview Rd.			10f. Zip Code 21136			10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>Specify:</small>		14. Race - American Indian, Black, White, etc. <small>Specify:</small> White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT Use retired) Clerk			16b. Kind of Business/Industry Wal-Mart				
	17. Father's Name (First, Middle, Last) George Ireland				18. Mother's Name (First, Middle, Maiden Surname) Kathryn Briguglio						
	19a. Informant's Name/Relationship (Type, Print) Michael Frainie (husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Greenview Ave. Reisterstown, MD 21136							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) S. Carroll Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) S. Carroll Crematory			Date 2/15/2007	20c. Location - City or Town, State Winfield, MD			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd Winfield, MD 21784							
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke								Approximate Interval Between Onset and Death 24 hours		
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { right atrial clot in heart Due to (or as a consequence of): c. heparin induced thrombocytopenia Due to (or as a consequence of): d.								4 days 5 days		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		
			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 		29c. License number Res- 000			29d. Date signed (Month, Day, Year) February 12, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Priscilla Brastianos, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21205										
	31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 4500
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rag. No. 2007 04419

1- For State Registrar		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year	3. Time of Death
Physician /Medical Examiner		Marvin James Fryer					Jan 29, 2007	0645 M
Funeral Director		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
		Hillhaven Healthcare			Adelphi		Prince George's	
To Be Completed by Funeral Director		5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 1, 1919	9. Birthplace (State or Foreign Country) Wisconsin
		Usual Residence of Decedent					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10a. State	10b. County	10c. City, Town or Location				
		Maryland	Prince George's	College Park				
		10e. Street and Number 9204 Dewberry Lane			10f. Zip Code 20740		10g. Citizen of What Country? United States	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Artist		16b. Kind of Business/Industry Self-Employed		
		17. Father's Name (First, Middle, Last) William Fryer			18. Mother's Name (First, Middle, Maiden Surname) Mabel Sutton			
		19a. Informant's Name/Relationship (Type, Print) Barbara H. Fryer/Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9204 Dewberry Ln., College Park, MD 20740			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cocklin Cemetery		Date 2/3/2007	20c. Location - City or Town, State Dillsburg, PA	
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave, LL., Silver Spring, MD 20910				
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Factor Underlying Cause (Disease or injury that initiated events resulting in death) Last						
		a. Stroke Due to (or as a consequence of):						
		b. Arterial Fibrillation Due to (or as a consequence of):						
		c. _____ Due to (or as a consequence of):						
		d. _____						
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Seizures, Amyloid						
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D52381		29d. Date signed (Month, Day, Year) 01/29/07		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robyn D. Anderson 10801 Lockwood Dr. Suite 205 Silver Spring, MD 20901						
		31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04420

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH A. FROST							2. Date of Death Month Day Year JANUARY 31 2007	3. Time of Death 4:30 PM M
	4a. Facility Name (If not institution, give street and number) 8606 DONCASTER ROAD				4b. City, Town, or Location of Death EASTON			4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 220-14-9753	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) OCT 14, 1925		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County TALBOT				10c. City, Town or Location EASTON				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 8606 DONCASTER ROAD				10f. Zip Code 21601		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry HOMEMAKER				
	17. Father's Name (First, Middle, Last) JOSEPH GRISBACH				18. Mother's Name (First, Middle, Maiden Surname) GEORGIA FENWICK				
	19a. Informant's Name/Relationship (Type, Print) KAREN F. MALEY/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8606 DONCASTER ROAD, EASTON, MD 21601				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR		Date	20c. Location - City or Town, State 2/2/2007 STEVENSVILLE, MD	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Joseph M. Ostrowski, C.F.S.P.</i>				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	<p>a. <i>myelodysplastic syndrome</i> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				
					23d. Date of delivery Month Day Year				
					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Robert B. Sanchez M.D.</i>				29c. License number D25750		29d. Date signed (Month, Day, Year) 2/2/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE, EASTON, MD 21601								
State Registrar	31. Date filed (Month, Day, Year) FEB - 2 2007				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantly: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

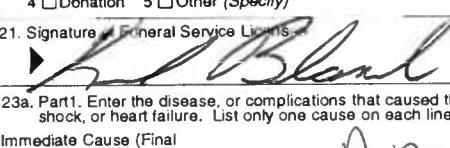
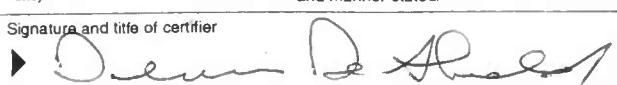
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04421

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLAUDIA E. FLANNERY							2. Date of Death Month Day Year January 28 2007	3. Time of Death 1323 M	
Funeral Director	4a. Facility Name (If not institution, give street and number) The Memorial Hospital			4b. City, Town, or Location of Death Easton			4c. County of Death Talbot			
	5. Social Security Number 079-44-3960	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) SEPT. 14, 1949	9. Birthplace (State or Foreign Country) NEW YORK	
Usual Residence of Decedent										
	10a. State MD	10b. County TALBOT	10c. City, Town or Location CORDOVA						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 31132 WILLIS ST.				10f. Zip Code 21625			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) DONALD J. FLANNERY					18. Mother's Name (First, Middle, Maiden Surname) RUTH L. ZIMMER				
	19a. Informant's Name/Relationship (Type, Print) LARRY FLANNERY/BROTHER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 CLARKS GAP COURT, MEDFORD, NJ 08055				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR 2/2/2007 STEVENSVILLE, MD			Date	20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee 									
	22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) Anoxic Encephalopathy									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Renal Failure									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown									
	23d. Date of delivery Month Day Year									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier  Dennis M. Deshields M.D.									
	29c. License number DOO 5310									
	29d. Date signed (Month, Day, Year) Jan 29 2007									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS M. DESHIELDS M.D. 219 S. WASHINGTON ST., EASTON, MD 21601									
	31. Date filed (Month, Day, Year) FEB - 1 2007									
	32. Registrar's Signature 									

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 2a or 2b, if show any injury or other traumatic event, a Medical Examiner must be notified at once.

Flannery, Claudia

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

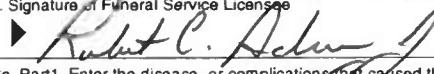
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04422

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deborah Ann Fisher					2. Date of Death Month Day Year January 21 2007	3. Time of Death 11:00 A M	
	4a. Facility Name (If not institution, give street and number) 124 Columbia Street			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 212-54-7805	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 5 1949	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Cumberland						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 124 Columbia Street			10f. Zip Code 21502		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3	16b. Kind of Business/Industry Nurse			Health Care	
	17. Father's Name (First, Middle, Last) Charles William Fisher			18. Mother's Name (First, Middle, Maiden Surname) Betty LaVerne (Strachan) Blake				
	19a. Informant's Name/Relationship (Type, Print) Tammy Fisher / sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 178 Spring Street, Frostburg, MD 21532					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory	Date 1/22/07	20c. Location - City or Town, State Cumberland, MD			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502					
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) PANCREATIC CANCER</p> <p>Approximate Interval Between Onset and Death 04/2000</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>LIVER AND LUNG METASTASIS</p> <p>a. Due to (or as a consequence of): PANCREATIC CANCER</p> <p>b. Due to (or as a consequence of): LIVER AND LUNG METASTASIS</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number 30063462			29d. Date signed (Month, Day, Year) 1/22/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alida Podrumar M.D.		31. Date filed (Month, Day, Year) JAN 22 2007					
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28-e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

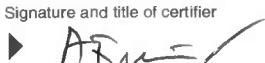
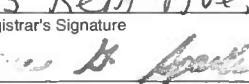
1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04423

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death M		
	John Fradiska				01 23 2007	1310 M		
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death		
	Memorial Hospital (WMHS)			Cumberland		Allegany		
	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) MARYLAND		
	220-10-0559		90		DEC. 1, 1916			
	Usual Residence of Decedent							
	10a. State MD	10b. County ALLEGANY	10c. City, Town or Location CRESAPTON			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 13605 CECIL AVENUE			10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry MAINTENANCE WORKER ALLEGANY COUNTY BOARD OF EDUCATION			
	17. Father's Name (First, Middle, Last) JOHN HENRY FRADISKA			18. Mother's Name (First, Middle, Maiden Surname) MARGARET E. HORCHLER				
	19a. Informant's Name/Relationship (Type, Print) GEORGE J. FRADISKA / SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 COUNTRY By WAY, YORK, PA 17402				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLCREST MEML. PARK		Date 01/26/2007	20c. Location - City or Town, State CUMBERLAND, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502			Approximate Interval Between Onset and Death		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. <i>Infarct Cerebral Bilateral</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D14389		29d. Date signed (Month, Day, Year) 01/24/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Figueras, M.D. - 625 Kent Ave., Cumberland, MD 21502							
	31. Date filed (Month, Day, Year) JAN 25 2007		32. Registrar's Signature 					

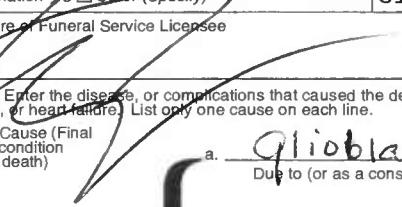
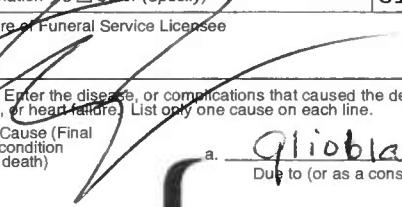
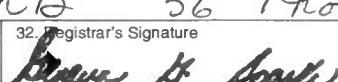
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04424

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Margaret Fogle				2. Date of Death Month Day Year January 29, 2007	3. Time of Death 12:45 AM	
	4a. Facility Name (If not institution, give street and number) Golden Living Nursing Home		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 214-28-0280	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 9, 1930	9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland		10b. County Frederick	10c. City, Town or Location Frederick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 205 Linden Avenue		10f. Zip Code 21703		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook & Server	14. Race - American Indian, Black, White, etc. Specify: White	
	17. Father's Name (First, Middle, Last) Lewis W. Brown		18. Mother's Name (First, Middle, Maiden Surname) Ella Margaret Thrasher				
	19a. Informant's Name/Relationship (Type, Print) Clarence M. Fogle / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Linden Ave. Frederick, MD 21703				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Clustered Spires Cem.		Feb. Date 1, 2007	20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Recent Pneumonia - Resolved.</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number D32245		29d. Date signed (Month, Day, Year) January 30, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amy Jones MD 56 Thomas Johnson Dr. Frederick						
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007	32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04425

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Camilla Fitzgerald							2. Date of Death Month January Day 31 , Year 2007	3. Time of Death 2:24 AM			
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 245-82-0801		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		If Under 1 Year Months 0 Days 0 Hours 0 Min. 0		8. Date of Birth (Month, Day, Year) April 20, 1932		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent Maryland		Montgomery		Silver Spring						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State Maryland				10b. County Montgomery				10c. City, Town or Location Silver Spring			
	10e. Street and Number 13315 Tamarack Road				10f. Zip Code 20904				10g. Citizen of What Country? USA			
Physician /Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White		14. Race - American Indian, Black, White, etc.					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher/Counselor		16b. Kind of Business/Industry Education					
Medical Certification: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Joseph Fitzgerald				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Marsden							
	19a. Informant's Name/Relationship, (Type, Print) Rachel Callahan, C.S.C.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13315 Tamarack Road, Silver Spring, MD 20904							
Medical Certification: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Feb. 3, 2007		20c. Location - City or Town, State Silver Spring, Maryland					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901									
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death				
	a. Liver Failure Due to (or as a consequence of): Decompensated Liver Cirrhosis											
Medical Certification: To Be Completed by Physician/Medical Examiner	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month 0 Day 0 Year 0000				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Small Bowel Obstruction							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
Medical Certification: To Be Completed by Physician/Medical Examiner	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier 				
Medical Certification: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Ruban, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910							29c. License number D65343				
	31. Date filed (Month, Day, Year) FEB 01 2007							32. Registrar's Signature 				

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01126

1- For
State
Registrar

**Physician
/Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) Laura Kathleen Gerrety			2. Date of Death Month Day Year January 25, 2007	3. Time of Death 4:00pm M
4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville	
5. Social Security Number 215-76-7419			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 49
8. Date of Birth (Month, Day, Year) Sept. 4, 1957			9. Birthplace (State or Foreign Country) Hawaii	
10a. State Maryland			10b. County Montgomery	
10c. City, Town or Location Potomac			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 10109 Colebrook Avenue			10f. Zip Code 20854	
10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) Donald W. Walter			18. Mother's Name (First, Middle, Maiden Surname) Rita Slate	
19a. Informant's Name/Relationship (Type, Print) Donald Gerrety (Spouse)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10109 Colebrook Avenue, Potomac, Maryland 20854	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► <i>Robert H. Gerrety</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery	Date 1/30/07	20c. Location - City or Town, State Silver Spring, Maryland
21. Signature of Funeral Service Licensee ► <i>Robert H. Gerrety</i>		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Minutes		
a. Due to (or as a consequence of): Cardiac Arrest				
b. Due to (or as a consequence of): Respiratory Failure				
c. Due to (or as a consequence of): COPD				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <i>VIDHI SINGH NIKHILANT, M.D.</i>		29c. License number DOO64560		29d. Date signed (Month, Day, Year) January 27th, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIDHI SINGH NIKHILANT, M.D. 9901 Medical Center Dr., Rockville, MD 20850				
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature <i>Barbara K. Gerrety</i>		

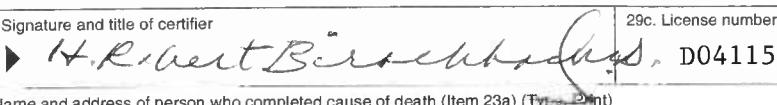
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 014627

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary K. Gartland					2. Date of Death Month Day Year January 28, 2007	3. Time of Death 10:50 A M	
	4a. Facility Name (If not institution, give street and number) Wilson Health Care			4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 055-38-3682	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 2, 1906	9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent 10a. State MD 10b. County Montgomery			10c. City, Town or Location Gaithersburg			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 12300 Morning Light Terrace			10f. Zip Code 20878		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry Registered Nurse			
	17. Father's Name (First, Middle, Last) John Klek			18. Mother's Name (First, Middle, Maiden Surname) Anna Cloplyi				
	19a. Informant's Name/Relationship (Type, Print) William J. Gartland Jr./ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12300 Morning Light Terrace, Gaithersburg, MD 20878				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Charles Cemetery		Date 2/1/2007	20c. Location - City or Town, State Farmingdale, New York		
	21. Signature of Funeral Service Licensee 							
	22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877							
Physician /Medical Examiner	<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Respiratory Failure</p> <p>a. Due to (or as a consequence of): Pneumonia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 2 Weeks</p>							
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>23b. Part 2. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Chronic bronchitis</p> <p>Recent myocardial infarction</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown </p> <p>23d. Date of delivery Month Day Year</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown </p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No </p>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D04115					
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) January 29, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robert Birschbach, 201 Russell Avenue, Gaithersburg, MD 20877							
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04428

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILIP GENTRY GRANT							2. Date of Death Month Day Year JANUARY 30 2007	3. Time of Death 5:55AM M
	4a. Facility Name (If not institution, give street and number) WILLIAM HILL MANOR			4b. City, Town, or Location of Death EASTON			4c. County of Death TALBOT		
Funeral Director	5. Social Security Number 562-01-9905	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) JAN 30, 1914	9. Birthplace (State or Foreign Country) KANSAS		
	Usual Residence of Decedent 10a. State CA 10b. County LOS ANGELES			10c. City, Town or Location VAN NUYS			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 13820 KITTRIDGE ST.				10f. Zip Code 91405			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SYSTEMS ANALYST			16b. Kind of Business/Industry AVIATION				
17. Father's Name (First, Middle, Last) WILLIAM INNIS GRANT					18. Mother's Name (First, Middle, Maiden Surname) KATE GENTRY				
19a. Informant's Name/Relationship (Type, Print) CAROLEE KENNEDY/DAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1050 N. STUART ST, #229 ARLINGTON, VA 22201				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLYWOOD FOREVER CEM. 2/10/2007			Date	20c. Location - City or Town, State LOS ANGELES, CA		
21. Signature of Funeral Service Licensee <i>Joseph M. Ostrach C.F.S.P.</i>					22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601				
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day, Year)</p> <p>28b. Time of Injury M</p> <p>28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier <i>William Harold J. M.D.</i></p> <p>29c. License number DO8715</p> <p>29d. Date signed (Month, Day, Year) 1/30/07</p> <p>30. Name and address of person who completed cause of death (Item 23d) (Type, Print) WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE, EASTON, MD 21601</p> <p>31. Date filed (Month, Day, Year) FEB - 1 2007</p> <p>32. Registrar's Signature <i>[Signature]</i></p>									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner will be notified at [redacted].

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04429

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)
Edith Virginia Gibson

2. Date of Death
Month Day Year
February 5, 2007

3. Time of Death
8:00 P M

4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's		
5. Social Security Number 577-20-3420		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) May 8, 1916		9. Birthplace (State or Foreign Country) District of Columbia

10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Leonardtown						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 21585 Peabody Street				10f. Zip Code 20650				10g. Citizen of What Country? USA			

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry U.S. Government					

17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Louise Cummings			
---	--	--	--	---	--	--	--

19a. Informant's Name/Relationship (Type. Print) Debra Flynn / Granddaughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 545, Machias, ME 04654					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Charles Memorial Gardens		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date February 9, 2007	20c. Location - City or Town, State Leonardtown, Maryland		

21. Signature of Funeral Service Licensee Michael Lewis Hardman		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650					
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Cancer with metastasis								Approximate Interval Between Onset and Death 3 years
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
--	--	---	--	--	--	---	--	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
--	--	--	--	--	--	--	--	--	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
---	--	---	--	--	--	--	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier SC Sajja M.D.							
---	--	---	--	--	--	--	--	--	--

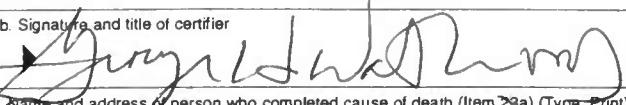
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chandra Sajja, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636		29c. License number D54346		29d. Date signed (Month, Day, Year) 2/6/07					
--	--	--------------------------------------	--	--	--	--	--	--	--

31. Date filed (Month Day Year) FEB 09 2007		32. Registrar's Signature John K. Aponte					
---	--	--	--	--	--	--	--

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 04430
Certificate of Death

1- For State Registrar		2. Date of Death Month Day Year JANUARY 29, 2007										Reg. No.			
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY CLARE GOLDRING										3. Time of Death 1:10PM ^M				
Funeral Director	4a. Facility Name (If not institution, give street and number) GENESIS LA PLATA CENTER					4b. City, Town, or Location of Death LA PLATA					4c. County of Death CHARLES				
To Be Completed by Funeral Director	5. Social Security Number 215-38-6172		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) APR. 12, 1919	9. Birthplace (State or Foreign Country) MARYLAND							
	Usual Residence of Decedent 10a. State MARYLAND 10b. County CHARLES 10c. City, Town or Location LA PLATA										10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number #1 MAGNOLIA DRIVE					10f. Zip Code 20646					10g. Citizen of What Country? U.S.A.				
Physician /Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK						
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAREGIVER					16b. Kind of Business/Industry PERSONAL HOMES				
	17. Father's Name (First, Middle, Last) SAM CAMPBELL					18. Mother's Name (First, Middle, Maiden Surname) CARRIE NEALE									
	19a. Informant's Name/Relationship (Type, Print) RUFUS GOLDRING-SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #10 35th STREET, SE, WASHINGTON, DC 20019									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MARY'S CHURCH CEM.			Date		20c. Location - City or Town, State 2-8-07 BRYANTOWN, MD							
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCINOSIS, SYNDROME WITH COVID-19 Due to (or as a consequence of): b. TUMORS OF LUNG, BRAIN, ABSCESS IN BRAIN Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death x 6 years				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)						23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
	29b. Signature and title of certifier 					29c. License number D20629					29d. Date signed (Month, Day, Year) 1/29/07				
	30. Name and address of person who completed cause of death (Item 2a) (Type, Print) George H. Wm. Jr., M.D. WOODROW, MD 20603														
State Registrar	31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature 												

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or Item 2a or 28a show any injury or other traumatic event. A Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Ws

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

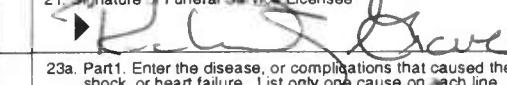
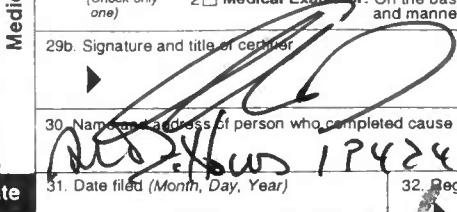
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For
State
Registrar

Amend #24a Per Verb G864 2/15/07 JH
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 04431

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death	
	May Della Hull							February 05, 2007	5:48 P M	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death		
	Homewood at Williamsport				Williamsport			Washington		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) February 01, 1912		9. Birthplace (State or Foreign Country) PA			
Usual Residence of Decedent		10a. State MD		10b. County Washington		10c. City, Town or Location Hancock		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 14463 Hollow Road		10f. Zip Code 21750		10g. Citizen of What Country? USA						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home						
17. Father's Name (First, Middle, Last) Fred Ray		18. Mother's Name (First, Middle, Maiden Surname) Annie Mann								
19a. Informant's Name/Relationship (Type, Print) J. Carl Hull/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14463 Hollow Road Hancock, MD 21750								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Stone Bridge Cemetery 02/08/07		Date	20c. Location - City or Town, State Hancock, MD					
21. Signature - Funeral Service Licensee 		22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368								
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. _____ Due to (or as a consequence of): Arteriosclerotic cardiovascular disease year b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus type II, hypertension Dementia</i>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D26806		29d. Date signed (Month, Day, Year) Feb 15, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MD D. Hull 17424 Powers Center Ave (Hancock MD 21742)</i>										
31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature <i>John B. Hale</i>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04432

1- For
State
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Polly Johnson Hanst			February 5, 2007			11:15 PM		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death	
	Goodwill Retirement Community				Grantsville			Garrett	
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
	213-18-2788						Dec. 8, 1906	West Virginia	
Usual Residence of Decedent									
10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
MD		Garrett		Oakland					
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?		
656 S. Third Street				21550			United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
Elementary/Secondary (0-12)		15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Public School	
4									
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
George Lee Johnson					Rosa Belle Matheny				
19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Jane Hanst Brown, Daughter					656 S. Third Street, Oakland, MD 21550				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State
					Kingwood Cemetery			2/13/07	Kingwood, WV
21. Signature of Funeral Service Licensee 									
22. Name and Address of Facility Burdock-Durst Funeral Home 21 N. Second St., Oakland, MD 21550									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line.									
23b. Approximate Interval Between Onset and Death Initial Cause (Final disease or condition resulting in death) inanition 2 Months									
23c. Subsequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dementia 5 years									
23d. Date of delivery Month Day Year									
23e. Did tobacco use contribute to the cause of death? chronic renal failure, stage four <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
26. Place of Death (Check only one)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29b. Signature and title of certifier  MD									
29c. License number D0025759									
29d. Date signed (Month, Day, Year) February 6, 2007									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K Naumann MD PO Box 247 Accident MD 21520									
31. Date filed (Month, Day, Year) FEB - 7 2007									
32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04433

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death	3. Time of Death			
	Alice Elizabeth Henley Harden					Month Day Year	1:10 P ^M			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	15675 Park Avenue			Brandywine			Charles			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)			
579-20-3125		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	Yrs. 84	Months	Days	Hours	Min.	Nov. 26, 1922	Virginia	
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location			10d. Inside City Limits	
		Maryland		Charles		Brandywine			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
15675 Park Avenue				20613			U S A			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White		
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 12			College (1-4 or 5+) Court Reporter			Court				
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
Aetius Bradshaw				Margaret Lillian Bradshaw						
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Lonnie Harden/Spouse				15675 Park Avenue, Brandywine, MD 20613						
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			Lakemont Memorial Gr.			2/9/2007	Davidsonville, MD			
21. Signature of Funeral Service Licensee			22. Name and Address of Facility							
▶ Tom Bach Jr.			Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)										
a. Due to (or as a consequence of): Non Hodgkin's lymphoma										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one)							
			Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier ▶ K Mathur			29c. License number 025352			29d. Date signed (Month, Day, Year) 2/7/06				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K MATHUR, P O Box 1703, La Plata MD 20646										
31. Date filed (Month, Day, Year) FEB 08 2007			32. Registrar's Signature ▶ K Mathur							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04434

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Hall					2. Date of Death Month February Day 7 , Year 2007	3. Time of Death 10:25 PM
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center			4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 218-52-6121	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) July 18, 1918	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's			10c. City, Town or Location Bushwood		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 22114 Colton Point Road				10f. Zip Code 20618		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Joseph Francis Lacey				18. Mother's Name (First, Middle, Maiden Surname) Annie Florence Vallandingham			
19a. Informant's Name/Relationship (Type. Print) Leroy Lacey / Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22130 Colton Point Road, Bushwood, Maryland 20618			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery		Date February 12, 2007	20c. Location - City or Town, State Bushwood, Maryland	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				
Physician /Medical Examiner	<p>23a. Part I (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Respiratory Failure</p> <p>b. Due to (or as a consequence of): Pneumonia</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death: hours</p> <p>Underlying Cause: 3 days</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Coronary Artery Disease</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D 06419				
29b. Signature and title of certifier 			29d. Date signed (Month, Day, Year) 2-8-07				
<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636</p>							
31. Date filed (Month, Day, Year) FEB 09 2007				32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 04435
Reg. No.1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, <

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Gary Albert Harris		February 6, 2007		0905 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
6411 Woodland Road		Suitland		Prince Georges
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 7, 1959
240-23-3819				9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent				
10a. State Md.	10b. County PG	10c. City, Town or Location Suitland		
10e. Street and Number 6411 Woodland Road		10f. Zip Code 20746		10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Truck Driver		16b. Kind of Business/Industry Private
17. Father's Name (First, Middle, Last) Albert Harris		18. Mother's Name (First, Middle, Maiden Surname) Joyce Pittman		
19a. Informant's Name/Relationship (Type, Print) Joyce Pittman Harris/ mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Olive Branch Blvd. Grifton, NC		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Family Cem. 2/10/07		Date 20c. Location - City or Town, State Grifton, NC
21. Signature of Funeral Service Licensee Joyce Edwards		22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Atherosclerotic Cardiovascular Heart Disease		
<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier Salvador Sylvester Jr.		29c. License number H0053927		29d. Date signed (Month, Day, Year) February 9, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland				
31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature Lorraine B. Sparto		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01 436

1- For
State
Registrar

Baltimore, Maryland 21215-0036
Division or Vital Records, P.O. Box 68760,
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Frances T. Lager		January 27 2007				3:00 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Anne Arundel Medical Center		Annapolis				Anne Arundel	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 87	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 1, 1919	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Annapolis				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 687 W. F. King Rd Harness Creek		10f. Zip Code 21403				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Thomas F. Taylor		18. Mother's Name (First, Middle, Maiden Surname) Elsa Katri Paakkonen					
19a. Informant's Name/Relationship (Type, Print) Eileen Lankford/Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Hollen Road Baltimore, MD 21212					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 1-29-2007		20c. Location - City or Town, State Catonsville, MD	
21. Signature of Funeral Service Licensee ► Sam Collins - Mith		22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Aspirator pneumonia				Approximate Interval Between Onset and Death 5 days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):					
23d. Date of delivery Month Day Year							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier ► Dr. James J. Deems	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. James J. Deems 2108 J. Dorsey Drive Annapolis MD 21409		29c. License number 033036				29d. Date signed (Month, Day, Year) 1/28/2007	
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature James A. Spotts				ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04 37

Reg. No.

1- For State Registrar		1. Decedent's Name (First, Middle, Last) Charles Anthony Iovino, Jr.						2. Date of Death Month January Day 30 , Year 2007	3. Time of Death 12:45 p M	
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) Montgomery Hospice-Casey House			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery		
Funeral Director		5. Social Security Number 577-22-8756	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 3, 1927	9. Birthplace (State or Foreign Country) Washington, DC		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State D.C. 10b. County - 10c. City, Town or Location Washington						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner		10e. Street and Number 1627 Kennedy Place, NW			10f. Zip Code 20011			10g. Citizen of What Country? USA		
Physician /Medical Examiner		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White		
Medical Certification: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney			16b. Kind of Business/Industry DC Government		
Baltimore, Maryland 21215-0036		17. Father's Name (First, Middle, Last) Charles A. Iovino, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Johnson					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) J. Robert Iovino/ Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4270 Woodhall Circle, Rockledge, FL 32955					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery			Date February 5, 2007	20c. Location - City or Town, State Washington, DC	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Francis J. Collins Funeral Home Inc . 500 University Blvd, W., Silver Spring, MD 20901					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Anaplastic Lung Cancer						Approximate Interval Between Onset and Death		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		a. Due to (or as a consequence of): Metastatic Anaplastic Lung Cancer Due to (or as a consequence of): b. c. d.								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death Check off one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number H0058032			29d. Date signed (Month, Day, Year) January 31, 2007		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Williams, D.O 6001 Muncaster Mill Road, Rockville, MD 20855								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		31. Date filed (Month, Day, Year) FEB 01 2007			32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#23a(a)perMD1/31/07, BMW, MoCo Certificate of Death

Reg. No.

2007 04438

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

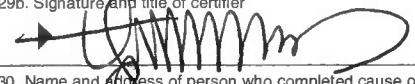
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 12:57 PM
PAPPAN JOHN		JANUARY 8, 2007		
4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY
5. Social Security Number 218-94-0482	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 15, 1928
Usual Residence of Decedent MARYLAND PRINCE GEORGE'S		10c. City, Town or Location LANHAM		9. Birthplace (State or Foreign Country) INDIA
10a. State MARYLAND		10b. County PRINCE GEORGE'S		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 6420 TIFFANY COURT		10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: ASIAN	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry DATA SPECIALIST COMPUTER COMPANY
17. Father's Name (First, Middle, Last) YOHANNAN PULIVARATHIL			18. Mother's Name (First, Middle, Maiden Surname) ALEYAMMA PULIVARATHIL	
19a. Informant's Name/Relationship (Type, Print) JOHN VARGHESE - SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4505 FRANKLIN TERRACE, BELTSVILLE, MARYLAND 20705		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY		Date 1/13/2007
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Septic Shock		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number D64491		29d. Date signed (Month, Day, Year) JANUARY 9, 2007
30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) MELISSA HYNES, M.D., 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910				
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
2007 04439
Certificate of Death

Reg. No.

For
State
Registrar
1-

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

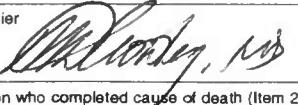
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Harwood D. Jackson		January 29 2007				1210 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Memorial Hospital at Easton		Easton				Talbot	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-14-4502			92 Yrs.			Jan. 6, 1915	Maryland
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Maryland	Talbot	Easton					
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
306 S. Washington St., Unit 2			21601			USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry Legal
17. Father's Name (First, Middle, Last) Samuel Omar Jackson				18. Mother's Name (First, Middle, Maiden Surname) Florence Elizabeth Willis			
19a. Informant's Name/Relationship (Type, Print) Beulah M. Jackson/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 S. Washington St., Unit 2, Easton, MD 21601			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State MidShoreCremationCenter 1/30/2007 Cambridge, Maryland	
21. Signature of Funeral Service Licensee <i>Harold D. Jackson - Bereavement</i>		22. Name and Address of Facility Mid Shore Cremation Center, P.O. Box 1464, 2272 Hudson Rd., Cambridge, MD 21613					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. <i>Fatal dysrhythmia</i> Due to (or as a consequence of):					
		b. <i>Ischemic cardiomyopathy</i> Due to (or as a consequence of):					
		c. <i>Coronary artery disease</i> Due to (or as a consequence of):					
		d. <i>Atherosclerosis, generalized</i> Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			M				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29b. Signature and title of certifier 		29c. License number <i>725933</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MD Crowley MD</i>		29d. Date signed (Month, Day, Year) <i>1-29-07</i>					
31. Date filed (Month, Day, Year) <i>EEB 01 2007</i>		32. Registrar's Signature <i>James B. Jackson</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 06440

1. For State Registrar

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Larry Antolin Joy

2. Date of Death
Month Day Year
February 4, 2007
3. Time of Death
1147 hrs

Funeral Director

4a. Facility Name (if not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death
Baltimore City

4c. County of Death

5. Social Security Number

213-11-5182

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

21

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)
November 21, 19859. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Leonardtown

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

21175 Marigold Street

10f. Zip Code

20650

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Flooring Installation

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Larry Paul Joy

18. Mother's Name (First, Middle, Maiden Surname)

Flora Thomas Laungayan

19a. Informant's Name/Relationship (Type, Print)

Flora Thomas Joy / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21175 Marigold Street, Leonardtown, Maryland 20650

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State4 Donation 5 Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Charles Memorial Gardens

Date

February 9, 2007

20c. Location - City or Town, State

Leonardtown, Maryland

21. Signature of Funeral Service License

Michael Sean Hardin

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Physician
/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy4 Pregnant at time of death 5 Other (Specify)9 Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther: 4 Nursing Home 5 Residence 6 Other

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending Investigation6 Could not be determined

28a. Date of Injury (Month, Day, Year)

FOUND: Feb 4, 2007

28b. Time of Injury

FOUND: 0630 hrs

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) In Vehicle

28f. Location (Street and Number or Rural Route Number, City or Town, State)

48304 Leachburg Road, Lexington Park, MD

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Melissa Brassell, MD Assistant Medical Examiner

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 5, 2007

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 06 2007

32. Registrar's Signature

Leanne B. Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04441

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year		3. Time of Death			
Loretta M. JACKSON		January 29 2007				0655 M					
1- For State Registrar		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death		4c. County of Death			
		Memorial Hospital				Easton		Talbot			
Physician /Medical Examiner		5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 24, 1939	9. Birthplace (State or Foreign Country) Baltimore, MD			
Funeral Director		10a. State MD				10b. County Dorchester					
		10c. City, Town or Location Hurstock				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director		10e. Street and Number 101 Miles Circle				10f. Zip Code 21643		10g. Citizen of What Country? U.S.A.			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mail Handler		16b. Kind of Business/Industry U.S. Postal Service			
		17. Father's Name (First, Middle, Last) Alfred Jackson Pawlak				18. Mother's Name (First, Middle, Maiden Surname) Rita Szczesniak					
		19a. Informant's Name/Relationship (Type, Print) BLANTON JACKSON - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Miles Circle, Hurstock, MD 21643					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOPKINS Cemetery		Date FEB. 1, 2007		20c. Location - City or Town, State Felton, DE			
		21. Signature of Funeral Service Licensee Donald P. Moore				22. Name and Address of Facility MOORE FUNERAL HOME, P.A. 125. Second St. Denton, MD 21629					
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Ventricular fibrillation</i> Due to (or as a consequence of): <i>Coronary artery disease</i> b. <i>Coronary artery disease</i> Due to (or as a consequence of): c. <i>Hypertension</i> Due to (or as a consequence of): d. <i>Gastrointestinal bleed</i> <i>Anemia</i> <i>Hypertension</i>								Approximate Interval Between Onset and Death days years	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Gastrointestinal bleed</i> <i>Anemia</i> <i>Hypertension</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> EP/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number 64043		29d. Date signed (Month, Day, Year) Jan. 29, 2007			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul W. Monte, MD		31. Date filed (Month, Day, Year) FEB 09 2007		32. Registrar's Signature James B. Gandy					

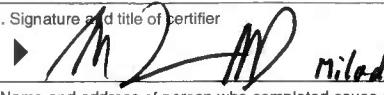
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Amend #5 Per INF G874 12/06/07 JH Certificate of Death

Reg. No. 2007 04442

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OK TAE KIM							2. Date of Death Month JANUARY Day 24 Year 2007	3. Time of Death 12:20P M
	4a. Facility Name (If not institution, give street and number) NATIONAL INSTITUTE OF HEALTH				4b. City, Town, or Location of Death BETHESDA			4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 4028 212-04-3943	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) AUGUST 25, 1948	9. Birthplace (State or Foreign Country) KOREA		
	Usual Residence of Decedent 10a. State MARYLAND 10b. County MONTGOMERY 10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 205 AMBERLEIGH DRIVE				10f. Zip Code 20905		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: ASIAN		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRESIDENT		16b. Kind of Business/Industry KOREAN-AMERICAN ASSOCIATION OF GREATER WASHINGTON		
	17. Father's Name (First, Middle, Last) JOONG SAN KIM				18. Mother's Name (First, Middle, Maiden Surname) WOO DAL CHO				
	19a. Informant's Name/Relationship (Type, Print) MYONG H. KIM - SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 AMBERLEIGH DRIVE, SILVER SPRING, MARYLAND 20905				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY		Date 1/30/2007	20c. Location - City or Town, State SILVER SPRING, MARYLAND		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Hepatic Failure</i></p> <p>b. Due to (or as a consequence of): <i>Cholangio Carcinoma</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							4 months	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i>							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number D57951		29d. Date signed (Month, Day, Year) 1, 24, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Milad Pooran MD</i>		10 CENTER DRIVE, BETHESDA, MD 20892						
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 011143

1 - For State Registrar

Physician / Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Majid Khadduri			Jan. 25, 2007 12:00 A M	
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death	
Manor Care Potomac			Potomac	
4c. County of Death		Montgomery		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 27, 1908
360-01-1693			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) Iraq
Usual Residence of Decedent		10a. State D.C.		
		10b. County		10c. City, Town or Location Washington
10e. Street and Number 4454 Tindall ST N.W.		10f. Zip Code 20016		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Professor Johns Hopkins Univ.
17. Father's Name (First, Middle, Last) Khadduri Khadduri			18. Mother's Name (First, Middle, Maiden Surname) Latifa Saati	
19a. Informant's Name/Relationship (Type, Print) Shirin Ghareeb / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5704 Cromwell Dr. Bethesda, Md. 20816	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Crematory		Date 1/30/07
21. Signature of Funeral Service Licensee ► William R. Bao		20c. Location - City or Town, State Falls Church, Va.		
22. Name and Address of Facility Joseph Gawler's Sons, Inc 5130 Wisconsin Ave N.W Washington D.C. 20016				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p style="text-align: center;"><i>FAILURE TO THRIVE</i></p> <p>a. Due to (or as a consequence of): <i>DEMENTIA</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
<p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier ► Trung Bao, MD		29c. License number 00057124		29d. Date signed (Month, Day, Year) 1/29/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trung Bao, M.D. 9715 Medical Center Drive; Rockville, MD 20850				
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Peter B. Aponte		

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier ► Trung Bao, MD		29c. License number 00057124		29d. Date signed (Month, Day, Year) 1/29/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trung Bao, M.D. 9715 Medical Center Drive; Rockville, MD 20850				
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Peter B. Aponte		

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 06444

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK MURRAY KENNEDY					2. Date of Death Month January Day 27 Year 2007	3. Time of Death 17:00 M		
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 215-32-1435		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months 0 Days 0 Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) August 5 1933	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent 10a. State Md.		10b. County Montgomery		10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 16533 South Westland Drive			10f. Zip Code 20877		10g. Citizen of What Country? United States			
Physician /Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1953- If Yes, Give Year or Dates: 1955		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Roofing Company			
Baltimore, Maryland 21215-0036	17. Father's Name (First, Middle, Last) Luke Mark Kennedy				18. Mother's Name (First, Middle, Maiden Surname) Lottie Virginia Murray				
Division or Vital Records, P.O. Box 68760,	19a. Informant's Name/Relationship (Type, Print) Mary Jane Kennedy / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16533 South Westland Dr., Gaithersburg, Md. 20877					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery		Date 2/1/07	20c. Location - City or Town, State Rockville, Md.			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death Unknown	
	<p>a. Due to (or as a consequence of): End Stage Chronic Pulmonary Lung Disease</p> <p>b. Due to (or as a consequence of): Pneumonia</p> <p>c. Due to (or as a consequence of): Sepsis</p> <p>d. Due to (or as a consequence of): Renal Failure</p>							Unknown	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								<p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 							28f. Location (Street and Number or Rural Route Number, City or Town, State) 	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29c. License number DOO 62999	
	29b. Signature and title of certifier Petele Donmez, MD							29d. Date signed (Month, Day, Year) January 28, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Petele Donmez, M.D. 11119 Rockville Pike, #401, Rockville, Md. 20852								
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Petele Donmez		ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

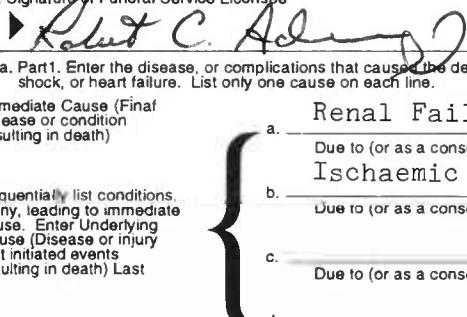
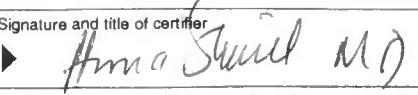
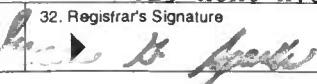
State of Maryland / Department of Health and Mental Hygiene

2007 04445

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Elaine Kline						2. Date of Death Month Day Year jan 22 2007	3. Time of Death 11:55 AM
	4a. Facility Name (If not institution, give street and number) Beverly Living Ctr of Cumberland			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany	
Funeral Director	5. Social Security Number 215-12-2228	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 5, 1920	9. Birthplace (State or Foreign Country) Ohio	
Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Cumberland 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 39 Humbird Street				10f. Zip Code 21502			10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home	
17. Father's Name (First, Middle, Last) Roy Reynolds				18. Mother's Name (First, Middle, Maiden Surname) Oda (Huff) Reynolds				
19a. Informant's Name/Relationship (Type, Print) Elaine Ritchie / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 E. Elder St., Cumberland, MD 21502				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory			Date 1/23/07	20c. Location - City or Town, State Cumberland, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Failure Due to (or as a consequence of): Ischaemic Cardiomyopathy Approximate Interval Between Onset and Death few weeks								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): few weeks								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D46346			29d. Date signed (Month, Day, Year) January 23, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huma Shakil, M.D. 625 Kent Avenue, Cumberland, MD 21502								
31. Date filed (Month, Day, Year) JAN 24 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

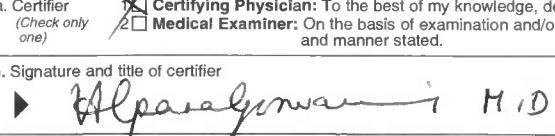
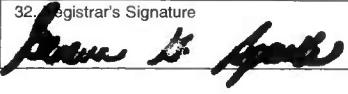
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04446

1- For
State
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) DOROTHY LEVINSON						2. Date of Death Month Day Year JANUARY 28, 2007		3. Time of Death 6:00 P M					
Funeral Director		4a. Facility Name (If not institution, give street and number) ARDEN COURTS						4b. City, Town, or Location of Death KENSINGTON		4c. County of Death MONTGOMERY					
To Be Completed by Funeral Director		5. Social Security Number 012-16-2931		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 91		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) NOVEMBER 29, 1915					
		Usual Residence of Decedent MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location KENSINGTON				9. Birthplace (State or Foreign Country) MASSACHUSETTS					
		10e. Street and Number 4301 KNOWLES AVENUE						10f. Zip Code 20895		10g. Citizen of What Country? U.S.A.					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4		16b. Kind of Business/Industry PERSONAL ASSISTANT				16c. Kind of Business/Industry FEDERAL LEGAL SYSTEM					
		17. Father's Name (First, Middle, Last) MORRIS LEVENTHAL						18. Mother's Name (First, Middle, Maiden Surname) REBECCA BERGER							
		19a. Informant's Name/Relationship (Type, Print) TOBY KAHN - DAUGHTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5636 BENT BRANCH ROAD, BETHESDA, MARYLAND 20816							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) KING DAVID MEMORIAL GARDENS		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 1/30/2007		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA							
		21. Signature of Funeral Service Licensee 						22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY b. Due to (or as a consequence of): PERIPHERAL VASCULAR DISEASE c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death													
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown						23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown							
		23d. Date of delivery Month Day Year						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)							
		27. Manner of death X <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred							
		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		29a. Certifier (Check only one) X <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29b. Signature and title of certifier 						29c. License number D-27660							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 ROCKVILLE PIKE SUITE 110 ROCKVILLE, MD 20852						29d. Date signed (Month, Day, Year) 1/29/07							
State Registrar		31. Date filed (Month, Day, Year) JAN 31 2007			32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DOROTHY LEVINSON
Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of DeathReg. No. **2007-01111**1- For State
Registrar

1. Decedent's Name (First, Middle, Last)

Borami Lim

2. Date of Death

Month Day Year

January 23, 2007

3. Time of Death

0833 hrs

**Physician/
Medical Examiner**

4a. Facility Name (if not institution, give street and number)

Fort Washington Hospital Center

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's**Funeral
Director**

5. Social Security Number

696-01-6912

6. Sex

 M F

7. Age (in yrs. last birthday)

7

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

Oct. 24, 19999. Birthplace (State or
Foreign Country)**Cambodia**

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Alexandria

10d. Inside City Limits

 Yes No

10e. Street and Number

2716 School Street

10f. Zip Code

22303

10g. Citizen of What Country?

Cambodia

11. Marital Status

 Never Married Married Widowed Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

 Yes NoIf Yes, Give Year
or Dates: Yes No

specify:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black,
White, etc.Specify: **Asian**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done
during most of working life DO NOT use retired)

College (1-4 or 5+)

Student

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Sareth Som

18. Mother's Name (First, Middle, Maiden Surname)

Thearoat Huy

19a. Informant's Name/Relationship (Type, Print)

Sareth Som - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2716 School St. Alexandria VA 22303

20a. Method of Disposition

 Burial Cremation Removal from State20b. Place of Disposition (Name of cemetery,
crematory or other place)**Everly Crematory**

Date

1/28/07

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensed

Pamela E. Southall**1136**

22. Name and Address of Facility

Everly Wheatley Funeral Home**1500 W Braddock Rd Alexandria VA 22302****Baltimore, MD 21215-0036**

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable cardiac arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

#25a.PIT.27,perME, g866, 4/12/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

 Yes No Unknown

23c. If yes, outcome of pregnancy

 Live birth Fetal death Ectopic pregnancy Pregnant at time of death Other (Specify) Unknown

23d. Date of delivery

Month

Day

Year

24a. Was an autopsy performed?

 Yes No

24b. Were autopsy findings available prior to completion of cause of death?

 Yes No

25. Was case referred to medical examiner?

 Yes No

26. Place of Death (Check only one)

Hospital:

 Inpatient ER/Outpatient DOA Other Nursing Home Residence Other

27. Manner of Death

 Natural Pending investigation Accident Suicide Could not be determined Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

 Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04448

Reg. No.

1- For
State
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death	
	Gladys Jane Leisner							Month Day Year			2135 M	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death			
	Memorial Hospital at Easton				Easton				Talbot			
	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth	9. Birthplace (State or Foreign Country)		
	216-24-4623		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	78 Yrs.	Months	Days	Hours	Min.	3/06/1928	Maryland		
Usual Residence of Decedent												
10a. State	10b. County		10c. City, Town or Location							10d. Inside City Limits		
MD	Caroline		Greensboro							<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number				10f. Zip Code					10g. Citizen of What Country?			
507 Vaughn Ave.				21639					U.S.A.			
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.		
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				Specify: White		
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry						
Elementary/Secondary (0-12) 08			College (1-4 or 5+) Homemaker							own home		
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)							
William Edward Cordrey					Mary Elizabeth Truitt							
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			Date			20c. Location - City or Town, State			
Pamela L. Delosier / daughter			507 Vaughn Ave; Greensboro, MD 21639			2/09/2007			Hurlock, MD			
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State			
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			Eastern Shore VetCem			2/09/2007			Hurlock, MD			
21. Signature of Funeral Service Licensee			22. Name and Address of Facility									
► Thomas K. Helfenstein			Fleegle and Helfenstein Funeral Home, PA PO Box 160; Greensboro, MD 21639									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death)												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
a. Due to (or as a consequence of): Hemorrhagic cerebrovascular accident Days												
b. Due to (or as a consequence of):												
c. Due to (or as a consequence of):												
d.												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify)			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
Hypertension												
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one)									
			Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier ► Lakshmi Vaidyanathan MD			29c. License number DO57749			29d. Date signed (Month, Day, Year) February 6 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
Lakshmi Vaidyanathan, MD 219 S. Washington St.; Easton, MD 21601												
31. Date filed (Month, Day, Year) FEB 12 2007			32. Registrar's Signature Newell									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04449
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Marie B. Lincoln							February 2, 2007	8:56A M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	14407 Danube Lane			Mitchellville			Prince Georges		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
084-28-8035			74			June 6, 1932	GA		
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
MD	PG	Mitchellville							
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?	
14407 Danube Lane				20721				United States	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12)		College (1-4 or 5+)			Executive Secretary			NASA	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
Edward Barnwell		Mary Ferebee							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Michelle Lawyer/daughter		14407 Danube Lane, Mitchellville, Md. 20721							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State	
		Riverdale Crematory 2/10/07						Riverdale, Md.	
21. Signature of Funeral Service Licensee <i>Grace Edwards</i>		22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death yrs							
{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <i>Progressive supranuclear palsy</i> Due to (or as a consequence of):							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>DY1978</i>							
29b. Signature and title of certifier <i>N.J. M.D.</i>		29d. Date signed (Month, Day, Year) <i>2-7-2007</i>							
Same and address of person who completed cause of death (Item 23a) (Type, Print) <i>Voder Law Office 4000 Mitchellville Rd A312 Bowie MD 20716</i>									
31. Date filed (Month, Day, Year) <i>FEB 14 2007</i>		32. Registrar's Signature <i>James B. Gandy</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend Item 2b per verb., G864, 02/15/07/0b Certificate of Death

2007 04450

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

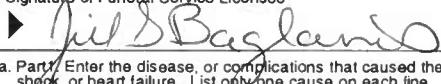
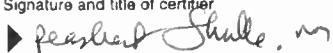
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Morsicato, James
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) James V. Morsicato	2. Date of Death Month Day Year February 9, 2007	3. Time of Death 0432 M				
4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital	4b. City, Town, or Location of Death Havre de Grace	4c. County of Death Harford				
5. Social Security Number 041-01-6219	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) Mar. 29, 1911	9. Birthplace (State or Foreign Country) Connecticut	
Usual Residence of Decedent 10a. State Florida 10b. County Broward			10c. City, Town or Location Ft. Lauderdale			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2427 N.E. 8th Street			10f. Zip Code 33304			10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Manager	16b. Kind of Business/Industry Restaurant				
17. Father's Name (First, Middle, Last) Louis Morsicato			18. Mother's Name (First, Middle, Maiden Surname) Benedetta Romano			
19a. Informant's Name/Relationship (Type, Print) Thomas Eric Morsicato (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18-C Owings Landing Ct. Perryville, MD 21093			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Evergreen Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Crematory	Date 2/19/07	20c. Location - City or Town, State New Haven, Conn.			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction			Approximate Interval Between Onset and Death one day			
b. Due to (or as a consequence of): 						
c. Due to (or as a consequence of): 						
d. Due to (or as a consequence of): 						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year 	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia Non-Insulin Diabetes Mellitus						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 			28f. Location (Street and Number or Rural Route Number, City or Town, State) 			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number 000048050			
29b. Signature and title of certifier 			29d. Date signed (Month, Day, Year) 2/19/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prashant Shukla, md 15 South Park Street #400 Aberdeen MD 21001						
31. Date filed (Month, Day, Year) FEB 15 2007			32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 0445

1- For State Registrar

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked than "natural", or items 23a or 28a-f show any
injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.To the Funeral Director: After this certificate has been signed by the attending physician and
completely filed in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

Sintia Mesa

2. Date of Death

Month January

Day 29

Year 2007

3. Time of Death

1350 hrs

4a. Facility Name (if not institution, give street and number)

7200 block Brook Crest Way

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

577-15-5261

6. Sex

M

F

7. Age (In yrs. last birthday)

25

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth (MM/DD/YYYY)

Hours

9. Birthplace (State or
Foreign Country)

Min.

Washington, DC

April 26, 1981

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland

Prince George's

Hyattsville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

5817 Chillum Gate Road

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Dominican/Salvadoran

Specify White

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

4

Aesthetician

16b. Kind of Business/Industry

Beauty Care

17. Father's Name (First, Middle, Last)

Francisco M. Mesa

18. Mother's Name (First, Middle, Maiden Surname)

Rosa M. Molina

19a. Informant's Name/Relationship (Type, Print)

Francisco M. Mesa/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5817 Chillum Gate Road, Hyattsville, MD 20782

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State4 Donation 5 Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

February 2

2007

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd, W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asphyxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)9 Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

</

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04452

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

ROLAND MARSHALL
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at once.

		2. Date of Death Month Day Year JANUARY 29 2007		3. Time of Death 2:15 AM^M
1. Decedent's Name (First, Middle, Last) ROLAND E. MARSHALL		4a. Facility Name (If not institution, give street and number) TALBOT HOSPICE HOUSE		4b. City, Town, or Location of Death EASTON
4c. County of Death TALBOT		5. Social Security Number 214-28-8427		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F
		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 11, 1928
		9. Birthplace (State or Foreign Country) MARYLAND		10. Usual Residence of Decedent
10a. State MD		10b. County TALBOT		10c. City, Town or Location TRAPPE
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3748 MARVEL DRIVE		10f. Zip Code 21673
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
				13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 OWNER		16b. Kind of Business/Industry BOATBUILDING
17. Father's Name (First, Middle, Last) PERCY R. MARSHALL		18. Mother's Name (First, Middle, Maiden Surname) EDITH POLLARD		
19a. Informant's Name/Relationship (Type, Print) SHIRLEY M. MARSHALL/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3748 MARVEL DRIVE, TRAPPE, MD 21673		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEMORIAL PARK		Date 2/2/2007
20c. Location - City or Town, State EASTON, MD		21. Signature of Funeral Service Licensee JOHN Z. MERCERON		22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cardiomyopathy, ischemic				Approximate Interval Between Onset and Death months years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last atherosclerosis				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. end stage Nephropathy		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at home		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 025-75-0		29d. Date signed (Month, Day, Year) 1/29/07
29b. Signature and title of certifier ROBERT B. SANCHEZ M.D.		29d. Date signed (Month, Day, Year) 1/29/07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE., EASTON, MD 21601		31. Date filed (Month, Day, Year) FEB - 1 2007		32. Registrar's Signature John Z. Merceron

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04453

1- For
State
Registrar

Physician
/Medical
Examiner

1. Physician / Medical Examiner		1. Decedent's Name (First, Middle, Last) Ralph Theodore Miller						2. Date of Death Month February Day 1 Year 2007		3. Time of Death 6:20 A M					
2. Funeral Director		4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home						4b. City, Town, or Location of Death Charlotte		4c. County of Death St. Mary's					
3. To Be Completed by Funeral Director		5. Social Security Number 578-10-1579		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		9. Date of Birth (Month, Day, Year) Jan. 1, 1919					
		10a. Usual Residence of Decedent Maryland		10b. County St. Mary's		10c. City, Town or Location Mechanicsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 27040 Burning Oaks Lane		10f. Zip Code 20659		10g. Citizen of What Country? U S A	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White							
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor		16b. Kind of Business/Industry Construction									
		17. Father's Name (First, Middle, Last) Theodore George Miller		18. Mother's Name (First, Middle, Maiden Surname) Mary Amelia Huseman											
		19a. Informant's Name/Relationship (Type, Print) Thelma R. Miller/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27040 Burning Oaks Lane, Mechanicsville, MD 20659											
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>[Signature]</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Cr.		Date 2/2/07		20c. Location - City or Town, State Charlotte Hall, MD							
		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622											
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Approximate Interval Between Onset and Death									
		a. CORONARY ARTERY DISEASE Due to (or as a consequence of):		b. Septic Shock Due to (or as a consequence of):		c. hypertension Due to (or as a consequence of):		d. hyperlipidemia							
		23d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year									
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chole lithiasis Chronic Kidney Disease Peripheral Vascular Disease		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27a. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <input type="checkbox"/> 28b. Time of Injury <input type="checkbox"/> 28c. Injury at Work? <input type="checkbox"/> M <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D45092		29d. Date signed (Month, Day, Year) 2/1/2007									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Rd Suite 205 Prince Frederick, MD 20678		31. Date filed (Month, Day, Year) FEB 05 2007		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

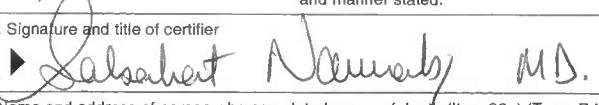
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04454

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TOMLA MERKEL				2. Date of Death 01 27 07		3. Time of Death 8:03 AM	
	4a. Facility Name (If not institution, give street and number) WHMS-BRADDOCK CAMPUS		4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 213-44-1240		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) JUNE 16, 1945	9. Birthplace (State or Foreign Country) MARYLAND
	10a. State MD		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 550 NORTH MECHANIC STREET			10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAITRESS & COOK			16b. Kind of Business/Industry RESTAURANT	
	17. Father's Name (First, Middle, Last) EARL MADARY				18. Mother's Name (First, Middle, Maiden Surname) KATHERINE ANN MORRIS			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) HARRY W. MERKEL, JR./HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 550 NORTH MECHANIC STREET, CUMBERLAND, MD 21502			Date	20c. Location - City or Town, State CUMBERLAND, MD	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY			01/29/2007		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502					
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. <u>UPPER Gastrointestinal Bleeding</u> Due to (or as a consequence of):</p> <p>b. <u>Esophageal CANCER</u> Due to (or as a consequence of):</p> <p>c. <u>SEPSIS</u>. Due to (or as a consequence of):</p> <p>d. <u>ANEMIA</u></p>							
	Approximate Interval Between Onset and Death 1 DAY							
	24 RS.							
	1 DAY.							
	1 DAY.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 							
	29c. License number D 58655							
	29d. Date signed (Month, Day, Year) 1/27/2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAJJAT NAWAB, MD 32 Corporate DR. GRANTSVILLE MD 21536							
State Registrar	31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division or Vital Records, P.O. Box 68760,

6
7/2007
NWS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04455

1- For State Registrar		2. Date of Death Month Day Year												3. Time of Death
Physician /Medical Examiner		Leonard Byron Mathias, Sr.						January 22 2007		1625 M				
Funeral Director		4a. Facility Name (If not institution, give street and number) Frostburg Village Nursing Home				4b. City, Town, or Location of Death Frostburg				4c. County of Death Allegany				
To Be Completed by Funeral Director		5. Social Security Number 236-20-9551		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct 30, 1922	9. Birthplace (State or Foreign Country) West Virginia					
		Usual Residence of Decedent		10a. State WV		10b. County Mineral		10c. City, Town or Location Ridgeley				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number Rt 1 Box 172				10f. Zip Code 26753				10g. Citizen of What Country? United States				
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Carman		16b. Kind of Business/Industry railroad								
		17. Father's Name (First, Middle, Last) Lee Franklin Mathias				18. Mother's Name (First, Middle, Maiden Surname) Effie (Stoltz) Mathias								
		19a. Informant's Name/Relationship (Type, Print) Leonard B. Mathias, Jr. / son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3288 Listonburg rd, Confluence, PA 15424										
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RestLawn Memorial		Date 1/26/07	20c. Location - City or Town, State LaVale, MD							
		21. Signature of Funeral Service Licensee ► Robert C. Adams J		22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502										
		23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Malignant Mesothelioma.				Approximate Interval Between Onset and Death 2 years						
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):										
		23d. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				Date of delivery Month Day Year						
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred						
		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
		29b. Signature and title of certifier ► Wonsook Shin MD		29c. License number DO055325				29d. Date signed (Month, Day, Year) Jan 23, 2007						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wonsook SHIN MD 48 Tarn Terrace Frostburg MD 21532												
		31. Date filed (Month, Day, Year) JAN 23 2007		32. Registrar's Signature ► Wonsook Shin										

Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial service.

Medical Certification: To Be Completed by Physician/Medical Examiner

3+1

Nes

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04456

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

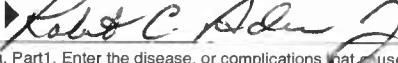
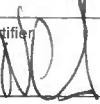
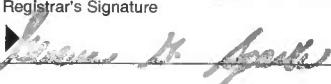
Physician
/Medical
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death
ROY ALFRED MANGES			Month	Day	Year	M
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death
WMHS-BRADDOCK CAMPUS			CUMBERLAND			ALLEGANY
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)		If Under 1 Year	
214-30-9872		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	74	Yrs.	Months	Days
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		10d. Inside City Limits		
06/01/1932		Maryland		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Usual Residence of Decedent			10c. City, Town or Location			
10a. State	10b. County	Cumberland				10d. Inside City Limits
MD	Allegany					<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?	
803 White Avenue			21502		USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		Specify: White
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		If Yes, Give Year or Dates Korean War				
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Insurance Agent			Insurance	
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)			
Alfred Roy Manges			Margaret Beatrice True			
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Norma L. Manges / wife			803 White Avenue, Cumberland, Maryland 21502			
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State			Sunset Memorial Park		01/27/2007	Cumberland, MD
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						
21. Signature of Funeral Service Licensee			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502			
						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.						
Immediate Cause (Final disease or condition resulting in death)						
Respiratory Failure						
Approximate Interval Between Onset and Death						
23b. Was decedent pregnant in the past 12 months?						
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
9 <input type="checkbox"/> Unknown						
23c. If yes, outcome of pregnancy						
1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy						
4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____						
9 <input type="checkbox"/> Unknown						
23d. Date of delivery						
Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death?						
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed?						
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death?						
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner?		26. Place of Death (Check only one)				
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation		M	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
3 <input type="checkbox"/> Suicide						
4 <input type="checkbox"/> Homicide						
29a. Certifier (Check only one)		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
2 <input type="checkbox"/> Medical Examiner		On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier		29c. License number			29d. Date signed (Month, Day, Year)	
		D0056355			January 25, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
Mark G. Nelson 902 Seton Drive Suite 204 Cumberland MD 21502						
31. Date filed (Month, Day, Year)		32. Registrar's Signature				
JAN 26 2007						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04457

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET MARY MADISON						2. Date of Death Month JANUARY Day 31 , Year 2007			3. Time of Death 9:15 A M		
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL			4b. City, Town, or Location of Death FREDERICK			4c. County of Death FREDERICK					
Funeral Director	5. Social Security Number 131-14-8252	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug. 19, 1926	9. Birthplace (State or Foreign Country) New York					
Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick										10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5955 Quinn Orchard Road				10f. Zip Code 21704			10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Telephone Operator			16b. Kind of Business/Industry Telephone					
17. Father's Name (First, Middle, Last) Salvatore Pitino					18. Mother's Name (First, Middle, Maiden Surname) Anna Rizzo							
19a. Informant's Name/Relationship (Type, Print) Janet Cugini / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3689 Mar-Lu-Ridge, Jefferson, MD 21755								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Calvary Cemetery			Date 2/5/07	20c. Location - City or Town, State Queens, New York				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death		
<p>a. Due to (or as a consequence of): Pneumonia</p> <p>b. Due to (or as a consequence of): Parkinsonian disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)						23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier 		29c. License number DS8391						29d. Date signed (Month, Day, Year) 1-31-07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAJJAD A. ALI, MD, 801 Toll House Ave, Frederick										31. Date filed (Month, Day, Year) FEB 02 2007		
										32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

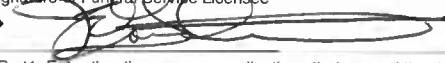
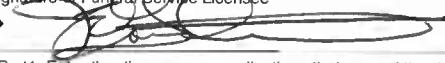
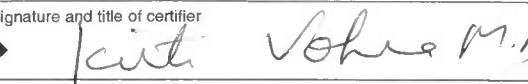
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04458

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dena MINTZ							2. Date of Death Month Day Year January 31, 2007			3. Time of Death 8:00 A M	
	4a. Facility Name (If not institution, give street and number) Manor Care Chevy Chase			4b. City, Town, or Location of Death Chevy Chase				4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 168-16-3393		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb. 22, 1907	9. Birthplace (State or Foreign Country) Russia				
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 1 East Lenox Street			10f. Zip Code 20815			10g. Citizen of What Country? United States					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Seamstress		16b. Kind of Business/Industry Women's Garments							
	17. Father's Name (First, Middle, Last) Morris Shore				18. Mother's Name (First, Middle, Maiden Surname) Tuba Korman							
	19a. Informant's Name/Relationship (Type, Print) Jamie Bramao, Grand-daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 E. Lenox St., Chevy Chase, MD 20815								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Sharon Cemetery			Date 02/02/07	20c. Location - City or Town, State Springfield, PA				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Advanced Dementia Due to (or as a consequence of): c. Anemia Due to (or as a consequence of): d. Osteoporosis											
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier  Kirti Vohra, M.D.								
				29c. License number D 20274			29d. Date signed (Month, Day, Year) January 31, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra, M.D., 7710 Bradley Blvd., Bethesda, MD 20817											
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended #5 per fh 2-9-07 Certificate of Death CCHD AS Reg. No. 2007 04459

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Lee Meredith							2. Date of Death Month FEB. Day 02, Year 2007	3. Time of Death 5:15 A M
	4a. Facility Name (If not institution, give street and number) 3 Belgrave Court			4b. City, Town, or Location of Death Easton			4c. County of Death Talbot		
Funeral Director	5. Social Security Number 220-26-7994		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov. 11, 1929	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State MD		10b. County Talbot		10c. City, Town or Location Easton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3 Belgrave Court			10f. Zip Code 21601			10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 48-52		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) District Manager			16b. Kind of Business/Industry Choptank Electric Corp.		
	17. Father's Name (First, Middle, Last) Lee Meredith				18. Mother's Name (First, Middle, Maiden Surname) Louise Gadow				
	19a. Informant's Name/Relationship (Type, Print) Pauline I. Meredith/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Belgrave Court, Easton, MD 21601				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Sh. Veterans		Date	20c. Location - City or Town, State Hurlock, Maryland		
	21. Signature of Funeral Service Licensee Michael J. Eskin			22. Name and Address of Facility Frampton Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Fibrosis Approximate Interval Between Onset and Death 1 year								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COPD								
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD								
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Timothy J. Sniezek								
	29c. License number D 53253								
	29d. Date signed (Month, Day, Year) Feb 05, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy J. Sniezek 136 Lednum Ave Preston, MD 21655								
	31. Date filed (Month, Day, Year) FEB 05 2007								
	32. Registrar's Signature Jesse B. Jones								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 01460

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Virginia Martin							2. Date of Death Month Day Year February 5, 2007	3. Time of Death 7:30 P.M.
	4a. Facility Name (If not institution, give street and number) Golden Living of Frederick				4b. City, Town, or Location of Death Frederick			4c. County of Death Frederick	
Funeral Director	5. Social Security Number 232-42-6622	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov. 20, 1926	9. Birthplace (State or Foreign Country) West Virginia		
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 7204 Bowers Road			10f. Zip Code 21702			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry homemaker				
	17. Father's Name (First, Middle, Last) Martin Archer				18. Mother's Name (First, Middle, Maiden Surname) Ethel Newkirk				
	19a. Informant's Name/Relationship (Type, Print) Jeffrey Martin, son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7204 Bowers Road, Frederick, Maryland 21702		20c. Location - City or Town, State Smithsburg, Maryland			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ryan M. Berger			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 2/10/2007			
	21. Signature of Funeral Service Licensee Ryan M. Berger			22. Name and Address of Facility Keeney and Basford Funeral Home		M00999 106 East Church Street, Frederick, MD 21701			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast cancer								Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): Breast cancer								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diarrhea								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29b. Signature and title of certifier Hemen Shah MD			29c. License number D0060417			29d. Date signed (Month, Day, Year) 2/7/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah MD 650 Thomas Johnson Dr, Frederick MD 21702								
State Registrar	31. Date filed (Month, Day, Year) FEB 14 2007			32. Registrar's Signature James B. Jones					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, <

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

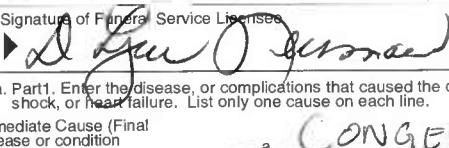
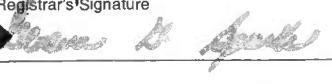
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04461

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WINIFRED NEWMAN				2. Date of Death Month 01 Day 28 Year 07 11:00 P.M.	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) WMHS BRADDOCK CAMPUS		4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY			
Funeral Director	5. Social Security Number 167-09-3563	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 8, 1910	9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent 10a. State PA 10b. County Somerset 10c. City, Town or Location Confluence				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 735 Williams St.			10f. Zip Code 15424		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc.				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	16b. Kind of Business/Industry Housewife	16c. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) John C. Lichliter			18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Rees				
	19a. Informant's Name/Relationship (Type. Print) Ward C. Newman			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Burgundy Dr., Lake St. Louis, MO 63367		Date 02/02/2007	20c. Location - City or Town, State Salisbury, PA	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Cemetery						
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Newman Funeral Home, Grantsville, MD 21536						
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 1 DAY						
	a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):							
	b. SEPSIS Due to (or as a consequence of):	1 DAY						
	c. ATRIAL FIBRILLATION Due to (or as a consequence of):	1 YEAR						
	d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Valve Disease. Coronary Artery disease			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D58655						
	29b. Signature and title of certifier 	29d. Date signed (Month, Day, Year) 1/30/2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabahat Nawab, 32 Corporate DR. GRANTSVILLE MD 21536.							
State Registrar	31. Date filed (Month, Day, Year) FEB - 5 2007	32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04462

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES JOHN O'DONNELL					2. Date of Death Month JAN. Day 30, Year 2007	3. Time of Death 8:44 P M			
	4a. Facility Name (If not institution, give street and number) 4909 ERIE ST.		4b. City, Town, or Location of Death COLLEGE PARK			4c. County of Death PRINCE GEORGES				
Funeral Director	5. Social Security Number 347-16-4265		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) JUNE 1, 1925	9. Birthplace (State or Foreign Country) ILLINOIS		
	10a. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location COLLEGE PARK			10d. Inside City Limits 1 Yes 2 No		
To Be Completed by Funeral Director	10e. Street and Number 4909 ERIE ST.			10f. Zip Code 20740		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1949-1953		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL TEACHER			16b. Kind of Business/Industry EDUCATION			
	17. Father's Name (First, Middle, Last) CHARLES R. O'DONNELL				18. Mother's Name (First, Middle, Maiden Surname) INEZ LYNETTE HOLMES					
	19a. Informant's Name/Relationship (Type, Print) PHYLLIS O'DONNELL/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4909 ERIE ST., COLLEGE PARK, MD. 20740							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) CHAMBERS CREMATORIUM		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 2-1-2007	20c. Location - City or Town, State RIVERDALE, MD.				
	21. Signature of Funeral Service Licensee M.W. Chambers M00091		22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737							
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEVERE IDIOPATHIC PULMONARY FIBROSIS Approximate Interval Between Onset and Death 10 YRS.									
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. POLYCLONAL GAMMOPATHY								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Other 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier C. De Lima M.D.		29c. License number D22755			29d. Date signed (Month, Day, Year) JAN. 31, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE DE LIMA, M.D. 7350 VAN DUSEN RD. SUITE 260, LAUREL, MD. 20707									
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature Debra S. Jones							

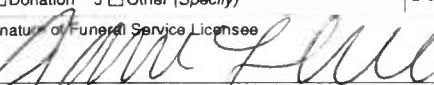
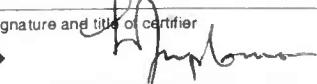
Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar		State of Maryland / Department of Health and Mental Hygiene		Amend Item 24a per verb., G&G, 02/5/07 dd. Certificate of Death		2007 04463		
						Reg. No.		
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) FLOELLEN N. PERSONS				2. Date of Death Month Day Year FEB. 8, 2007		3. Time of Death 12:00p M
Funeral Director		4a. Facility Name (If not institution, give street and number) 201 FOREST DRIVE		4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
To Be Completed by Funeral Director		5. Social Security Number 213-24-5658		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days Hours <input type="checkbox"/> Min.	8. Date of Birth (Month Day, Year) Oct 16, 1927	9. Birthplace (State or Foreign Country) MD
		Usual Residence of Decedent						
		10a. State MD	10b. County Allegany	10c. City, Town or Location Cumberland				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number 201 Forest Drive		10f. Zip Code 21502		10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <input type="checkbox"/> Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <input type="checkbox"/> white		14. Race - American Indian, Black, White, etc. Specify: <input type="checkbox"/> white
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) telephone operator		16b. Kind of Business/Industry C&P Telephone Co.		
		17. Father's Name (First, Middle, Last) John W. Stafford		18. Mother's Name (First, Middle, Maiden Surname) Elsie Mae Messick Stafford				
		19a. Informant's Name/Relationship (Type, Print) Alvin Persons		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) husband 201 Forest Drive Cumberland MD 21502		Date 2/12/2007		
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		20c. Location - City or Town, State Cumberland MD		
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue, Cumberland, MD 21502				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease		Approximate Interval Between Onset and Death 10 yrs		
		23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Date of delivery Month Day Year				
		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		23h. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23i. 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23j. 28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		23k. 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		23l. 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 20033280		29d. Date signed (Month, Day, Year) Feb 9, 2007		
		29b. Signature and title of certifier 		29c. License number 20033280		29d. Date signed (Month, Day, Year) Feb 9, 2007		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta, M.D.		31. Date filed (Month, Day, Year) FEB 15 2007		32. Registrar's Signature 		
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036						ORIGINAL		
Physician /Medical Examiner								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.								
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial/transit								
Medical Certification: To Be Completed by Physician/Medical Examiner								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04464

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Puthenpurackal Korah Punnoose						2. Date of Death Month Day Year January 29, 2007	3. Time of Death 6:30 AM
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 216-11-7944	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov 7, 1913	9. Birthplace (State or Foreign Country) India	
	Usual Residence of Decedent Maryland Montgomery		10c. City, Town or Location Potomac				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 9704 Clagett Farm Dr				10f. Zip Code 20854			10g. Citizen of What Country? India
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Asian			14. Race - American Indian, Black, White, etc. Specify: Asian
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Accountant				16b. Kind of Business/Industry Accounting
17. Father's Name (First, Middle, Last) Korah Punnoose					18. Mother's Name (First, Middle, Maiden Surname) Annamma Korah			
19a. Informant's Name/Relationship (Type, Print) Kuruvilla Abraham/Son In Law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 645 Elmcroft Blvd, #13206, Rockville, MD 20850				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sts. Peter & Paul Ortho Feb 9, 2007 Kerela, India			Date	20c. Location - City or Town, State Kerela, India	
21. Signature of Funeral Service Licensee Alaf Howell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death							
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Acute Myocardial Infarction Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Congestive Heart Failure								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner		29b. Signature and title of certifier Daniel Goldberg, MD						
		29c. License number D21334			29d. Date signed (Month, Day, Year) January 29, 2007			
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature Susan A. Spangler						

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

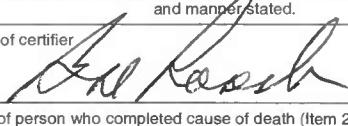
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04465
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norman A. PISNER				2. Date of Death Month Day Year January 29, 2007	3. Time of Death 1:40 P M	
	4a. Facility Name (If not institution, give street and number) 10718 Douglas Avenue		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578-24-6007	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 14, 1925	If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington, DC		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 10718 Douglas Avenue			10f. Zip Code 20902	10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white	14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager/Owner		16b. Kind of Business/Industry Restaurant		
	17. Father's Name (First, Middle, Last) Herman Pisner			18. Mother's Name (First, Middle, Maiden Surname) Celia Siegel			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gary Pisner, Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12111 Fairfax Hunt Road, Fairfax, VA 22030				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens		Date 02/01/07	20c. Location - City or Town, State Olney, MD	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Minutes				
	a. Due to (or as a consequence of): Acute Myocardial Infarction						
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
	d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number D 09834		29d. Date signed (Month, Day, Year) January 30, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Rosenbaum, M.D., 3720 Farragut Avenue, Kensington, MD 20895						
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 				

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04466

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death	3. Time of Death		
	Marcella E. Paugh					01 Month	26 Day	2007 Year	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	WMHS - Memorial Hospital			Cumberland			Allegany		
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)	
	234-64-2843		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	84 Yrs.	Months	Days	Hours Min.	Nov. 7, 1922	West Virginia
Usual Residence of Decedent									
10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits	
WV		Mineral		Elk Garden				1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?		
Rt. 1, Box 283				26717			United States		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White	
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 10		College (1-4 or 5+)		Homemaker			Own Home		
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
Henry Rhodes					Laura Paugh				
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Jerry Lee Paugh, Son				Rt. 1, Box 283, Elk Garden, WV 26717					
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			Kalbaugh Cemetery			1/30/2007	Elk Garden, WV		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility					
<i>Katherine Sweitzer</i>				David A. Burdock Funeral Home 710 Church St., Kitzmiller, MD 21538					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
a. Cerebrovascular accident Due to (or as a consequence of):									
b. Cerebral arteriosclerosis Due to (or as a consequence of):									
c. _____ Due to (or as a consequence of):									
d. _____ Due to (or as a consequence of):									
Approximate Interval Between Onset and Death									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Possibly pacemaker malfunction, hypotension, coronary artery disease.									
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
							28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
							28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 19318							
29b. Signature and title of certifier <i>N. A. Ranjithan</i>		29d. Date signed (Month, Day, Year) Jan 30th 2007							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nagaratnam Ranjithan, MD 517 Oldtown Road Cumberland, MD 21502									
31. Date filed (Month, Day, Year) FEB - 2 2007		32. Registrar's Signature <i>Sherri B. Parker</i>							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

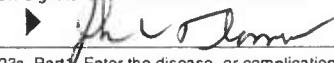
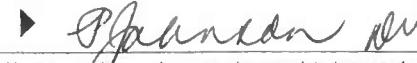
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No:

2007 04467

1- For
State
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Maggie Willey Phillips						2. Date of Death Month Day Year January 29 2007	3. Time of Death 10:08 p.m.				
	4a. Facility Name (If not institution, give street and number) Chesapeake Woods Center			4b. City, Town, or Location of Death Cambridge			4c. County of Death Dorchester					
Funeral Director	5. Social Security Number 219-07-3380	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) April 3, 1919	9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent 10a. State MD 10b. County Dorchester			10c. City, Town or Location Taylors Island			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 4413 Hoopers Neck Road			10f. Zip Code 21669			10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1940			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home					
	17. Father's Name (First, Middle, Last) Elmer Willey			18. Mother's Name (First, Middle, Maiden Surname) Fannie Horseman								
	19a. Informant's Name/Relationship (Type, Print) Steven Henry grandson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6010 Greenview Court, Seaford, DE 19973								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dorchester Mem. Park			20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Mem. Park			Date 2/2/07	20c. Location - City or Town, State Cambridge, MD				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613								
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pneumonia Approximate Interval Between Onset and Death 2 weeks											
	b. dementia Due to (or as a consequence of): hypertension Due to (or as a consequence of): 10 years 20 years											
	c. hypertension Due to (or as a consequence of): d.											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) 1/3/07			
	29b. Signature and title of certifier 								29c. License number H0059973			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Johnson 100 Bramble St, Cambridge, MD											
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e show any injury or other traumatic event, **ALL MEDICAL EXAMINER INFORMATION IS REQUIRED**.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04468

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley Eston Propst							2. Date of Death Month Day Year January 29, 2007	3. Time of Death 1250 M			
	4a. Facility Name (If not institution, give street and number) Memorial Hospital			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany					
Funeral Director	5. Social Security Number 215-36-9408	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months 8	If Under 24 Hrs. Days 2	Hours 00	Min. 00	8. Date of Birth (Month, Day, Year) 07/24/1938	9. Birthplace (State or Foreign Country) West Virginia			
	Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Cumberland 10d. Inside City Limits 1 X Yes 2 □ No											
To Be Completed by Funeral Director	10e. Street and Number 220 Somerville Avenue				10f. Zip Code 21502			10g. Citizen of What Country? USA				
	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Truck Driver								
17. Father's Name (First, Middle, Last) Homer		18. Mother's Name (First, Middle, Maiden Surname) Glenn Propst		19a. Informant's Name/Relationship (Type, Print) Barbara Wentling / sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12203 Cresap Mill Road, Oldtown, MD 21555						
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glendale Cemetery		20c. Date 02/01/2007		20c. Location - City or Town, State Flintstone, MD						
21. Signature of Funeral Service Licensee Robert C. Adams				22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Lung Disease								Approximate Interval Between Onset and Death 20 years			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23f. Was an autopsy performed? 1 □ Yes 2 X No		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)		27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred	
							28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Vik Poonai, M.D., 924 Seton Drive, Cumberland, MD 21502				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier D. Adams		29c. License number D36766		29d. Date signed (Month, Day, Year) January 30, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vik Poonai, M.D., 924 Seton Drive, Cumberland, MD 21502		31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature John B. Spotts								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04469

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Dawe Penrose						2. Date of Death Month Day Year 2 7 07 AM	3. Time of Death Hour Min. 11:00 AM
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital			4b. City, Town, or Location of Death Leonardtown			4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 012-26-6127	6. Sex M	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 7, 1936	9. Birthplace (State or Foreign Country) Massachusetts	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's 10c. City, Town or Location Mechanicsville 10e. Street and Number 35380 Golf Course Drive 10f. Zip Code 20659 10g. Citizen of What Country? U S A							
	11. Marital Status Married	12. Was Decedent Ever in U.S. Armed Forces? Yes	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) No	14. Race - American Indian, Black, White, etc. White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Facilities Supervisor	16b. Kind of Business/Industry Polymer Technology					
	17. Father's Name (First, Middle, Last) Horace Penrose	18. Mother's Name (First, Middle, Maiden Surname) Zena Whittle						
	19a. Informant's Name/Relationship (Type, Print) Carol M. Penrose/Spouse	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35380 Golf Course Drive, Mechanicsville, MD 20659						
	20a. Method of Disposition Burial	20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gr.	Date 2/12/2007	20c. Location - City or Town, State Leonardtown, Maryland				
	21. Signature of Funeral Service Licensee Ronald Baste St	22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622						
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Retroperitoneal Hematoma							Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): Possible acute hemorrhage							
	b. Due to (or as a consequence of): Vascular accident							
	c. Due to (or as a consequence of): 							
	d. 							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes	23c. If yes, outcome of pregnancy Live birth	3 Ectopic pregnancy	23d. Date of delivery Month Day Year				
		Fatal death	Other (specify)					
		Pregnant at time of death						
		Unknown						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency Heart valve replacement								23e. Did tobacco use contribute to the cause of death? No
	25. Was case referred to medical examiner? No	Hospital: Inpatient	26. Place of Death (Check only one) Other	27. Manner of Death Natural	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? Yes	28d. Describe how injury occurred
		2	4 Nursing Home	5 Residence	3 ER/Outpatient	6 Other (Specify)		
					28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		28d. Describe how injury occurred
	29a. Certifier (Check only one) Certifying Physician	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated						
		29b. Signature and title of certifier Rakhi Krishnan						
	31. Date filed (Month, Day, Year) FEB 09 2007	32. Registrar's Signature Jeanne B. Parker	29c. License number D 60888	29d. Date signed (Month, Day, Year) 2-7-07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rakhi Krishnan								
31. Date filed (Month, Day, Year) FEB 09 2007								
32. Registrar's Signature Jeanne B. Parker								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

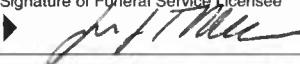
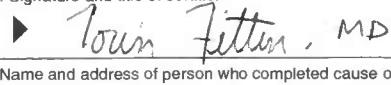
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 01-170

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bruce Rink							2. Date of Death Month January Day 26 Year 2007	3. Time of Death 3:45 PM
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City			4c. County of Death		
Funeral Director	5. Social Security Number 227-04-8861	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 5	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) JUN 1, 1959	9. Birthplace (State or Foreign Country) Peru		
	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery			10c. City, Town or Location Potomac			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 9421 Sunnyfield Ct.				10f. Zip Code 20854		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Peru	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) Financial Advisor			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Advisor			16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) Frederick William Rink				18. Mother's Name (First, Middle, Maiden Surname) Teresa Garcia				
	19a. Informant's Name/Relationship (Type, Print) Cartalina Rink/Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9421 Sunnyfield Ct., Potomac, MD 20854					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) National Memorial Park			20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial Park		Date 2/1/2007	20c. Location - City or Town, State Falls Church, VA		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL, Silver Spring, MD 20910					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Aortic Root Replacement Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 weeks
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) 23d. Date of delivery Month 0 Day 0 Year 0
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								29c. License number RES-000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TORIN FITTON, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND								29d. Date signed (Month, Day, Year) January 26, 2007
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Within 24 hours after death.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

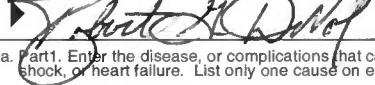
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04471

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernice A. Reese						2. Date of Death Month Day Year January 28, 2007	3. Time of Death 8: 20 AM				
	4a. Facility Name (If not institution, give street and number) Brooke Grove Nursing Home			4b. City, Town, or Location of Death Sandy Spring			4c. County of Death Montgomery					
Funeral Director	5. Social Security Number 350-03-2855		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 94	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	8. Date of Birth (Month, Day, Year) June 1, 1912	9. Birthplace (State or Foreign Country) Illinois				
	Usual Residence of Decedent 10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 3400 Glenmoor Drive			10f. Zip Code 20815			10g. Citizen of What Country? United States					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1940		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home					
	17. Father's Name (First, Middle, Last) Frank Krueger				18. Mother's Name (First, Middle, Maiden Surname) Nora Gilbert							
	19a. Informant's Name/Relationship (Type, Print) George K. Reese, Jr. (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9016 Copenhagen Drive, Potomac, MD 20854								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Metropolitan Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 1/29/07	20c. Location - City or Town, State Alexandria, Virginia					
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Years			
	<p>a. Myelodysplastic Syndrome Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown								23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Atrial Fibrillation, Hypertension, Coronary Artery Disease								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) January 29, 2007	28b. Time of Injury M 1	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1	28d. Describe how injury occurred
									28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29b. Signature and title of certifier 								29c. License number D23958			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burt I. Feldman, M.D. 3305 N. Leisure World Blvd., Silver Spring, MD 20906								29d. Date signed (Month, Day, Year) January 29, 2007			
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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12

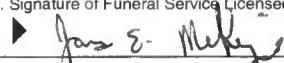
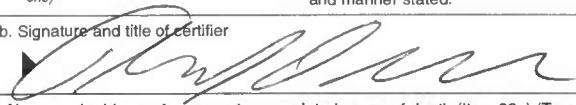
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04472

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGUERITE RAYNER					2. Date of Death Month Day Year 02 01 07	3. Time of Death 2:20PM^M			
	4a. Facility Name (If not institution, give street and number) WMHS BRADDOCK CAMPUS			4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY				
Funeral Director	5. Social Security Number 215-20-6363	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) March 14, 1919	9. Birthplace (State or Foreign Country) West Virginia				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Allegany 10c. City, Town or Location Lonaconing						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 57 Jackson Street			10f. Zip Code 21539		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 0	16b. Kind of Business/Industry Nurses Assistant		16c. Kind of Business/Industry Hospital				
	17. Father's Name (First, Middle, Last) Thomas Stewart James				18. Mother's Name (First, Middle, Maiden Surname) Louise Statler					
	19a. Informant's Name/Relationship (Type, Print) James T. Rayner - Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19308 Paradise Hill Lane SW, Frostburg, Maryland, 21532						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Cemetery		Date February 06, 2007	20c. Location - City or Town, State Lonaconing, Maryland				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street, Lonaconing, MD 21539						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 1 day			
	<p>a. <i>Sepsis</i> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant et time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Generalized atherosclerosis, Congestive heart failure, Aortic stenosis. History of Subarachnoid hemorrhage.</i>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one)		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29d. Date signed (Month, Day, Year)		
	29b. Signature and title of certifier 		29c. License number D0021488					29d. Date signed (Month, Day, Year) Feb 1, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Devlin MD, 20 Douglas Ave, Lonaconing, MD 21539									
State Registrar	31. Date filed (Month, Day, Year) FEB - 5 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division or Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

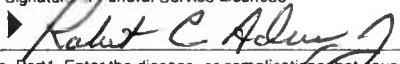
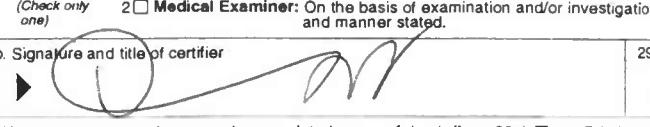
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04473

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis Anne Rivers-Gambers						2. Date of Death Month Day Year January 18 2007	3. Time of Death 1950 M		
	4a. Facility Name (If not institution, give street and number) WMHS Braddock Campus			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany			
Funeral Director	5. Social Security Number 016-30-2076	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05/09/1938	9. Birthplace (State or Foreign Country) Massachusetts			
	Usual Residence of Decedent 10a. State WV 10b. County Mineral						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number P.O. Box 761 (Sunset View)						10f. Zip Code 26719	10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	16b. Kind of Business/Industry Director of Membership			Public Television			
17. Father's Name (First, Middle, Last) Francis Arthur Rivers						18. Mother's Name (First, Middle, Maiden Surname) Kathryn F. (Lyons)				
19a. Informant's Name/Relationship (Type, Print) Ronald P. Gamber / husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 761 Fort Ashby, WV 26719				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory	Date 01/20/2007	20c. Location - City or Town, State Cumberland, MD					
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Approximate Interval Between Onset and Death 24 months										
a. Due to (or as a consequence of): Metastatic Breast Cancer										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. _____										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 	29c. License number D0023371	29d. Date signed (Month, Day, Year) January 19, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qamar Zaman, M.D. 625 Kent Avenue, Cumberland, MD 21502										
31. Date filed (Month, Day, Year) JAN 22 2007				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04474

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

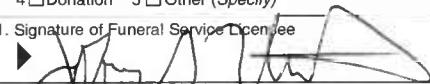
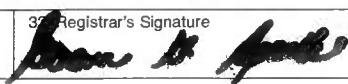
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Alice Ruth Hazelton Searle		2. Date of Death Month January Day 28 Year 2007		3. Time of Death 2:26 PM	
4a. Facility Name (If not institution, give street and number) Casey House		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 001-14-4727		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.	
				8. Date of Birth (Month, Day, Year) March 15, 1918	9. Birthplace (State or Foreign Country) New Hampshire
Usual Residence of Decedent					
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Bethesda			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 9714 DePaul Drive			10f. Zip Code 20817		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Musician Music	
17. Father's Name (First, Middle, Last) Earnest Morton Hazelton			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth French		
19a. Informant's Name/Relationship (Type, Print) Edward Everett Searle, Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9714 DePaul Drive, Bethesda, Maryland 20817			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date January 30, 2007	20c. Location - City or Town, State Alexandria, Virginia
21. Signature of Funeral Service Licensee 					
22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, Maryland 20877					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. Due to (or as a consequence of): Pneumonia</p> <p>b. Due to (or as a consequence of): Alzheimer's Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number H0058032			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 1-29-2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O., 6001 Muncaster Mill Rd., Rockville, MD 20855					
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04475

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Violet Schade						2. Date of Death Month Day Year January 28, 2007	3. Time of Death 6:40 a m	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital			4b. City, Town, or Location of Death Olney			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579-12-6128	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 26, 1918	9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent 10a. State Maryland			10b. County Montgomery			10c. City, Town or Location Silver Spring	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3148 Adderley Court				10f. Zip Code 20906			10g. Citizen of What Country? USA		
To Be Completed by Funeral Director	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1940			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contract Administrator			16b. Kind of Business/Industry Contracting			
17. Father's Name (First, Middle, Last) Andrew C. Schade				18. Mother's Name (First, Middle, Maiden Surname) Violet A. Mahorney					
19a. Informant's Name/Relationship (Type, Print) Helen Koch/ Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11776 Stratford House Place, #1004, Reston, VA 20190					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Fort Lincoln Cemetery				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			Date Feb. 1, 2007	20c. Location - City or Town, State Brentwood, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequelae myocardial infarction				Approximate Interval Between Onset and Death					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pulmonary edema									
a. Due to (or as a consequence of): Pneumonia									
b. Due to (or as a consequence of): Pneumonia									
c. Due to (or as a consequence of): Pneumonia									
d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown Other (specify) _____					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 1/28/07		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home								28f. Location (Street and Number or Rural Route Number, City or Town, State) 18101 Prince Philip Dr. Olney MD 20832	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 0059414					29d. Date signed (Month, Day, Year) 1/28/07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vladimir M. Rakhamanov, MD									
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04476

Reg. No.

1 - For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Phyllis Maxine Spangler			Feb 5 2007	4:42 PM
4a. Facility Name (If not institution, give street and number) 13522 Old Legislative Rd			4b. City, Town, or Location of Death Frostburg	
4c. County of Death Allegany				
5. Social Security Number 215-26-9910			6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.
			If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
			8. Date of Birth (Month, Day, Year) June 11 1929	9. Birthplace (State or Foreign Country) MD

Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, **if a Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death. Within 24 hours after death, To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, **if a Medical Examiner must be notified at once.**

State
Registrar

To Be Completed by Funeral Director

10a. State MD	10b. County Allegany	10c. City, Town or Location Frostburg	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 13522 Old Legislative Rd		10f. Zip Code 21532	10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Unknown	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker	16b. Kind of Business/Industry Home	
17. Father's Name (First, Middle, Last) William Beveridge		18. Mother's Name (First, Middle, Maiden Surname) Zella Miller	

19a. Informant's Name/Relationship (Type, Print) Gary Spangler/son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Glenfield Ct, Virginia Beach, VA 23454
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Robert J. Spangler	20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory
	Date
	20c. Location - City or Town, State Cumberland, MD

21. Signature of Funeral Service Licensee Robert J. Spangler	22. Name and Address of Facility Boal Funeral Home, 111 Church St Westernport, Md 21562
--	---

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure	Approximate Interval Between Onset and Death 5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic obstructive Lung Disease	Approximate Interval Between Onset and Death 20 years
a. Due to (or as a consequence of): Respiratory Failure	
b. Due to (or as a consequence of): Chronic obstructive Lung Disease	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify) Other	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast Cancer, Hyper tension. Coronary artery disease		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Thomas J. Devlin MD, 20 Douglas Ave., Lonaconing MD 21539				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number 00021488	29d. Date signed (Month, Day, Year) Feb. 5, 2007
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Devlin MD, 20 Douglas Ave., Lonaconing MD 21539	32. Registrar's Signature John A. Jones
31. Date filed (Month, Day, Year) FEB - 6 2007	32. Registrar's Signature John A. Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

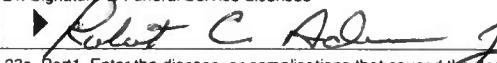
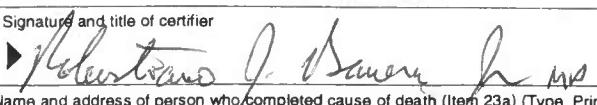
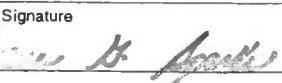
State of Maryland / Department of Health and Mental Hygiene

2007 04477

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elva Arbutus Smith							2. Date of Death Month Day Year January 29 2007	3. Time of Death 6:10 P M
	4a. Facility Name (If not institution, give street and number) 13711 Uhl Highway SE			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany		
Funeral Director	5. Social Security Number 220-28-9632	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 20, 1916	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent 10a. State MD 10b. County Allegany			10c. City, Town or Location Cumberland			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 13711 Uhl Highway SE			10f. Zip Code 21502			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) James Jackson Smith				18. Mother's Name (First, Middle, Maiden Surname) Ardith (Price) Smith					
19a. Informant's Name/Relationship (Type, Print) Shirley A. Steele / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13711 Uhl Highway SE, Cumberland, MD 21502					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Hermon Cemetery			Date Feb 2, 2007	20c. Location - City or Town, State Cumberland, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):			Approximate Interval Between Onset and Death 6 mos		
				b. CORONARY ARTERY DISEASE Due to (or as a consequence of):			ONE YR.		
				c. Due to (or as a consequence of):					
				d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number D0014865						29d. Date signed (Month, Day, Year) January 30, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano J. Barrera, M.D.		32. Registrar's Signature 							
31. Date filed (Month, Day, Year) JAN 30 2007									

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

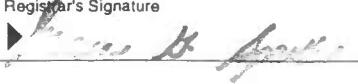
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04478

1- For State Registrar		2. Date of Death Month Day Year January 26, 2007 02:00 PM M										Reg. No.					
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Eugene A. Smith, Jr.										3. Time of Death					
Funeral Director		4a. Facility Name (If not institution, give street and number) 37 Frost Avenue										4b. City, Town, or Location of Death Frostburg					
		5. Social Security Number 309-18-4307		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months 0	II Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) May 02, 1913	9. Birthplace (State or Foreign Country) Maryland								
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland										10b. County Allegany	10c. City, Town or Location Frostburg	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		10e. Street and Number 37 Frost Ave.										10f. Zip Code 21532-	10g. Citizen of What Country? U.S.A.				
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White									
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 officer		16b. Kind of Business/Industry Army											
		17. Father's Name (First, Middle, Last) Eugene A. Smith, Sr.										18. Mother's Name (First, Middle, Maiden Surname) Emily Heath Townsend					
		19a. Informant's Name/Relationship (Type, Print) Eugene A. Smith, III son										19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Frost Ave. Frostburg Maryland 21532					
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park		Date February 02, 2007		20c. Location - City or Town, State Frostburg Maryland									
		21. Signature of Funeral Service Licensee 										22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death year year					
		<p>a. <i>Ischaemic cardiomyopathy</i> Due to (or as a consequence of):</p> <p>b. <i>Arteriosclerosis</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>															
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Demeter</i>										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
												24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred									
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner		29b. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
		29c. License number DOO17565		29d. Date signed (Month, Day, Year) Jan 29, 2007													
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>AJ Bellin MD 922 N 21st Hwy Lubbock ND 79421</i>															
State Registrar		31. Date filed (Month, Day, Year) JAN 30 2007		32. Registrar's Signature 													

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

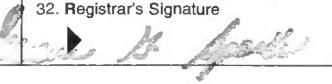
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

9/1/VA
NBA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 04479
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sara Jane Stein							2. Date of Death Month 01 Day 29 Year 07	3. Time of Death 1450 M		
	4a. Facility Name (If not institution, give street and number) WMHS Braddock Campus				4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany			
Funeral Director	5. Social Security Number 215-26-9405		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 27, 1929	9. Birthplace (State or Foreign Country) Maryland			
	10a. State MD		10b. County Allegany		10c. City, Town or Location LaVale			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 12511 Gramlich Rd SW				10f. Zip Code 21502		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Homemaker						
	17. Father's Name (First, Middle, Last) Ford Lee				18. Mother's Name (First, Middle, Maiden Surname) Blanche (Weber)						
	19a. Informant's Name/Relationship (Type, Print) Paul J. Stein / husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12511 Gramlich Rd SW, LaVale, MD 21502			20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Lawn Memorial			Date 2/2/2007		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20c. Location - City or Town, State LaVale, MD					
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Dystonia									Approximate Interval Between Onset and Death immediate	
	Sequentially list conditions, Any cause is immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Attherosclerosis									Approximate Interval Between Onset and Death years	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ventricular irritability, Megaceen syndrome									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State) 12511 Gramlich Rd SW, LaVale, MD 21502		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0017565			29d. Date signed (Month, Day, Year) Jan. 30, 2007					
	29b. Signature and title of certifier 										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.J. Bellino MD 922 N 21st Hwy LaVale MD 21502										
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial transit completely filled in by the funeral director.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04480

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM KENNETH SCHELL				2. Date of Death Month 01 Day 31 Year 2007	3. Time of Death 1040 M																																		
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL		4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY																																			
Funeral Director	5. Social Security Number 218-12-5873	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 82	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04/17/1924	9. Birthplace (State or Foreign Country) Maryland																																	
	Usual Residence of Decedent 10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																	
To Be Completed by Funeral Director	10e. Street and Number 700 Rose Avenue			10f. Zip Code 21502		10g. Citizen of What Country? USA																																		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Military		16b. Kind of Business/Industry U.S. Army																																				
	17. Father's Name (First, Middle, Last) William Grahm Schell			18. Mother's Name (First, Middle, Maiden Surname) Teresa Scott																																				
	19a. Informant's Name/Relationship (Type, Print) Debra D. Erickson / daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 S. Bedford Street, Bedford, PA 15522																																				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>[Signature]</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) MD Vet. Cem. @Rocky Gap		Date 02/05/2007	20c. Location - City or Town, State Flintstone, MD																																	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Ronald C. Adney Jr.</i>			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502																																				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Approximate Interval Between Onset and Death 5 DAYS																																							
	<table border="0"> <tr> <td>a.</td> <td colspan="7">Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT</td> </tr> <tr> <td>b.</td> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="7"></td> </tr> </table>								a.	Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT							b.	Due to (or as a consequence of):							c.	Due to (or as a consequence of):							d.							
a.	Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT																																							
b.	Due to (or as a consequence of):																																							
c.	Due to (or as a consequence of):																																							
d.																																								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year																																		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																																	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																																	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred																																	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																																			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																							
	29b. Signature and title of certifier <i>D. Poonai</i>		29c. License number D36766		29d. Date signed (Month, Day, Year) February 1, 2007																																			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIK POONAI		31. Date filed (Month, Day, Year) FEB 01 2007																																					
State Registrar			32. Registrar's Signature <i>John B. Parker</i>																																					

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

111VA

NRL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04481

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ida Summy					2. Date of Death Month 01 Day 25 Year 07 1450 M	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) WMHS Braddock Campus			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany			
Funeral Director	5. Social Security Number 217-54-9467	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) APRIL 7, 1938	9. Birthplace (State or Foreign Country) PA		
To Be Completed by Funeral Director	10a. State PA			10b. County SOMERSET	10c. City, Town or Location MEYERSDALE	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 274 YODER RD			10f. Zip Code 15552		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 8		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Home maker		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home maker		16b. Kind of Business/Industry HOME				
	17. Father's Name (First, Middle, Last) DANIEL KINSINGER			18. Mother's Name (First, Middle, Maiden Surname) HYDIA KINSINGER					
	19a. Informant's Name/Relationship (Type, Print) ALVIN Summy			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 274 YODER RD MEYERSDALE PA 15552					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) M Ray Leckemby			20b. Place of Disposition (Name of cemetery, crematory or other place) Summit Hills Am. Cemetery	Date 1/28/07	20c. Location - City or Town, State MEYERSDALE PA			
	21. Signature of Funeral Service Licensee M Ray Leckemby			22. Name and Address of Facility M Ray Leckemby Funeral Home					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLISM							Approximate Interval Between Onset and Death 24 hours	
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {								
	a. Due to (or as a consequence of): PULMONARY EMBOLISM	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier William Lamm MD	29c. License number D25406							
	29d. Date signed (Month, Day, Year) JANUARY 25, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Lamm MD 900 Seton Drive Cumberland Maryland 21502								
State Registrar	31. Date filed (Month, Day, Year) FEB 02 2007	32. Registrar's Signature John B. Lester							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1
2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04482

Physician /Medical Examiner Funeral Director	<p>1- For State Registrar</p> <p>1. Decedent's Name (First, Middle, Last) ELIZABETH BRIDGET SALMON</p> <p>2. Date of Death Month Day Year January 30, 2007</p> <p>3. Time of Death 8:55 PM</p> <p>4a. Facility Name (If not institution, give street and number) THE LIONS CENTER</p> <p>4b. City, Town, or Location of Death CUMBERLAND</p> <p>4c. County of Death ALLEGANY</p> <p>5. Social Security Number 202-03-9460</p> <p>6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) 90 Yrs.</p> <p>If Under 1 Year If Under 24 Hrs. Months Days Hours Min.</p> <p>8. Date of Birth (Month, Day, Year) APR. 25, 1916</p> <p>9. Birthplace (State or Foreign Country) PENNSYLVANIA</p> <p>10a. State MD</p> <p>10b. County ALLEGANY</p> <p>10c. City, Town or Location CUMBERLAND</p> <p>10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>10e. Street and Number 323 AVIRETT AVENUE</p> <p>10f. Zip Code 21502</p> <p>10g. Citizen of What Country? U.S.A.</p> <p>11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</p> <p>12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:</p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</p> <p>14. Race - American Indian, Black, White, etc. Specify: WHITE</p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12</p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER</p> <p>16b. Kind of Business/Industry HOME</p> <p>17. Father's Name (First, Middle, Last) MICHAEL CONBOY</p> <p>18. Mother's Name (First, Middle, Maiden Surname) BRIDGET FITZPATRICK</p> <p>19a. Informant's Name/Relationship (Type, Print) JOHN SALMON / SON</p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 AVIRETT AVENUE, CUMBERLAND, MD 21502</p> <p>20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) UPCHURCH FUNERAL HOME, P.A.</p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY</p> <p>Date 02/02/2007</p> <p>20c. Location - City or Town, State CUMBERLAND, MD</p> <p>21. Signature of Funeral Service Licensee Skerry D. Lockwood</p> <p>22. Name and Address of Facility 202 GREENE STREET, CUMBERLAND, MD 21502</p> <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)</p> <p>23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</p> <p>23f. Approximate Interval Between Onset and Death 7 days</p> <p>23g. Advanced Dementia</p> <p>23h. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced Dementia</p> <p>23i. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</p> <p>23j. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier Wonsok Shin, MD</p> <p>29c. License number # D55325</p> <p>29d. Date signed (Month, Day, Year) January 31, 2007</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wonsok Shin, MD 48 Tarn Terrace Frostburg, MD 21502</p> <p>31. Date filed (Month, Day, Year) FEB 01 2007</p> <p>32. Registrar's Signature B. Spillman</p>							
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

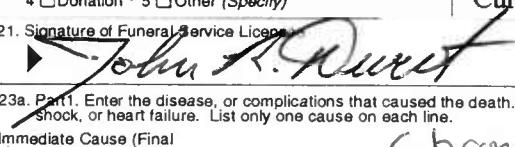
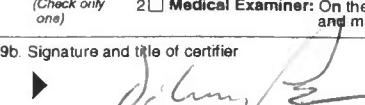
Medical Certification: To Be Completed by Physician/Medical Examiner

Salmon, Elizabeth B.
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 04683

1- For State Registrar		2. Date of Death Month Day Year		3. Time of Death	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)	January 28, 2007		1:40 A M	
	Edith Ella Starkey				
Funeral Director	4a. Facility Name (If not institution, give street and number) Western Maryland Health System's Frostburg Nursing & Rehab Center 213-64-9193	4b. City, Town, or Location of Death Frostburg		4c. County of Death Allegany	
To Be Completed by Funeral Director	5. Social Security Number 6. Sex 7. Age (Yrs. Mo. Ds. Mths. Ds. Days. Min.) 1 M 2 F 102 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) July 25, 1904	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10d. Inside City Limits 1 Yes 2 No
	10a. State Maryland	10b. County Allegany	10c. City, Town or Location Frostburg		
	10e. Street and Number 144 West Main Street	10f. Zip Code 21532-		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	16b. Kind of Business/Industry homemaker		
	17. Father's Name (First, Middle, Last) Charles Wegman	18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Stains daughter		19. Informant's Name/Relationship (Type, Print) Minnie Gerlach	
	19a. Informant's Name/Relationship (Type, Print) Elizabeth Stains daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 West Main Street Frostburg Maryland 21532		Date January 29, 2007	20c. Location - City or Town, State Cumberland Maryland
Physician /Medical Examiner	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory	20c. Location - City or Town, State Cumberland Maryland		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Chronic Renal Failure			Approximate Interval Between Onset and Death 10 years
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year		
	25. Was case referred to medical examiner? 1 □ Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)			23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 			
	29c. License number D36766	29d. Date signed (Month, Day, Year) January 28, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vikramaditya Poonai 924 Seton Drive Cumberland Md 21502	31. Date filed (Month, Day, Year) JAN 29 2007			
	32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or if item 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

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Rev. DB
2/05

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04484

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Joseph Stevens							2. Date of Death Month Day Year January 23, 2007	3. Time of Death M 14:33	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany		
Funeral Director	5. Social Security Number 213-06-0074	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) July 02, 1968	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent										
	10a. State Maryland	10b. County Allegany	10c. City, Town or Location Frostburg						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 12008 Kemp Drive, N.W.				10f. Zip Code 21532-			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) foster care worker	16b. Kind of Business/Industry social services							
	17. Father's Name (First, Middle, Last) Ronald Stevens				18. Mother's Name (First, Middle, Maiden Surname) Sandra Hoyle					
	19a. Informant's Name/Relationship (Type, Print) Ronald Stevens father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12008 Kemp Drive, N.W. Frostburg Maryland 21532					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Restlawn Memorial Gardens				20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens		Date Jan 26, 2007	20c. Location - City or Town, State La Vale Maryland		
	21. Signature of Funeral Service Licensee John R. Durst				22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Toxin overdose with medical complications								Approximate Interval Between Onset and Death 7 days	
	b. Due to (or as a consequence of): Ethylene glycol ingestion								7 days	
	c. Due to (or as a consequence of): Balmer									
	d. Due to (or as a consequence of): Balmer									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one) pt ingested toxin			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 1/16/07		28b. Time of Injury 11:44	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred residence			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence								28f. Location (Street and Number or Rural Route Number, City or Town, State) 12008 Kemp Dr F' Burg MD	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D26907							
	29b. Signature and title of certifier H. Sidhu		29d. Date signed (Month, Day, Year) JANUARY 25, 2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Harjit Sidhu 925 Bishop Walsh Road CUMBERLAND, MD 21502									
	31. Date filed (Month, Day, Year) JAN 25 2007		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5
D.B.
Nas

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04486

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Houshang Soumekhian</i>				2. Date of Death Month <input checked="" type="checkbox"/> JAN Day <input checked="" type="checkbox"/> 27 Year <input checked="" type="checkbox"/> 2007	3. Time of Death <input checked="" type="checkbox"/> 1750 M			
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE	4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number <input checked="" type="checkbox"/> unk		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <input checked="" type="checkbox"/> 12/14/1930	9. Birthplace (State or Foreign Country) <input checked="" type="checkbox"/> IRAN	
	Usual Residence of Decedent		10a. State <input checked="" type="checkbox"/> MARYLAND 10b. County <input checked="" type="checkbox"/> MONTGOMERY 10c. City, Town or Location GAITHERSBURG				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 252 GOLD KETTLE DRIVE			10f. Zip Code 20878		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RETAILER		16b. Kind of Business/Industry AUTO PARTS				
	17. Father's Name (First, Middle, Last) SHAUL SOUMEKHIAN				18. Mother's Name (First, Middle, Maiden Surname) ZEEVAR "UNKNOWN"				
	19a. Informant's Name/Relationship (Type, Print) SINA SOUMEKHIAN/SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 JAY DRIVE, ROCKVILLE, MARYLAND 20850					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GARDEN OF REMEMBRANCE		Date <input checked="" type="checkbox"/> 01/28/2007	20c. Location - City or Town, State CLARKSBURG, MARYLAND		
	21. Signature of Funeral Service Licensee <i>Carlton</i>			22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. Due to (or as a consequence of): <i>Seizures</i></p> <p>b. Due to (or as a consequence of): <i>Respiratory Failure</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	Approximate Interval Between Onset and Death <i>>10 Days</i> <i>>30 Days</i>								
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	23f. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) <input checked="" type="checkbox"/> 12/14/2006 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Osagie J. Mekonwu</i>								
	29c. License number D 60168								
	29d. Date signed (Month, Day, Year) JAN 27, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASERA J. MEKONWU, MD 1201 Seven Hills Rd., Rockville, MD 20850								
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature <i>Bethany A. Jones</i>						

Baltimore, Maryland 21215-0036

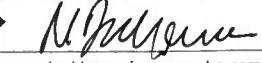
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #19b Per State of Maryland Department of Health and Mental Hygiene
AMEND#14 per FH2/6/07, BMW, MoCo Certificate of Death Reg. No. 2007 04487

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Pecolia Spence				2. Date of Death Month Day Year January 30, 2007	3. Time of Death 3:25A. M		
	4a. Facility Name (If not institution, give street and number) Independence Court		4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 215-62-7864	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month Day Year) April 23, 1925	9. Birthplace (State or Foreign Country) South Carolina		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Hyattsville						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 5821 Queens Chapel Road		10f. Zip Code 20782		10g. Citizen of What Country? United states			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Black Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Custodial	16b. Kind of Business/Industry PG Co. Schools					
	17. Father's Name (First, Middle, Last) John Walker		18. Mother's Name (First, Middle, Maiden Surname) unk					
	19a. Informant's Name/Relationship (Type, Print) Ruth S. Sweet -Personal Rep.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16111 Riffle Ford Road Gaithersburg, Maryland 20875					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory	Date 1/31/2007	20c. Location - City or Town, State Alexandria, Virginia			
Physician /Medical Examiner	21. Signature of Funeral Service Licensed ► 		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death 2 years	
	<p>a. Breast Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) January 30, 2007	
	29b. Signature and title of certifier ► 						29c. License number D64234	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas DeMonaco, M.D. 7525 Greenway Center Drive, #215 Greenbelt, Maryland 20770							
State Registrar	31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. All medical records must be retained for 3 years.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04488

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,
Baltimore, Maryland 21205-68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
George W. Swain		01 27 2007		1603 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
University of Maryland Medical Center		Baltimore		
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 21, 1942
238-64-6974				9. Birthplace (State or Foreign Country) N. Carolina
Usual Residence of Decedent				
10a. State MD	10b. County Prince Geo	10c. City, Town or Location Lanham		
10e. Street and Number 6218 Brightlea Drive		10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Meat Cutter	16b. Kind of Business/Industry Giant Food		
17. Father's Name (First, Middle, Last) George W. Swain, Sr		18. Mother's Name (First, Middle, Maiden Surname) Lola Harrell		
19a. Informant's Name/Relationship (Type, Print) Della G. Swain (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6218 Brightlea Dr., Lanham, MD 20706		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cem	Date 2/4/07	20c. Location - City or Town, State Brentwood, MD
21. Signature of Funeral Service Licensee George R. Snowden		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death				Approximate Interval Between Onset and Death
<p>a. abdominal sepsis Due to (or as a consequence of):</p> <p>b. duodenal perforation Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				3 days
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent colostomy for lower GI bleed history of heart transplant and immunosuppression				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Nora Meenaghan, MD		29c. License number AU4176435M/6179		29d. Date signed (Month, Day, Year) 01/27/2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nora Meenaghan, MD 22 S. Greene Street, Baltimore, MD 21201				
31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature Suzanne B. Spotts		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 04489

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 3:09 A M
Mabel Schwartz		January 30, 2007				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
15210 Elkridge Way, Apt. 3G		Silver Spring				Montgomery
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.
053-12-8206						
8. Date of Birth (Month, Day, Year) 08/28/1920						
9. Birthplace (State or Foreign Country) New York						
10a. State MD		10b. County Montgomery	10c. City, Town or Location Silver Spring			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 15210 Elkridge Way, Apt. 3G		10f. Zip Code 20906				10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper		16b. Kind of Business/Industry Retail		
17. Father's Name (First, Middle, Last) Herman Feinberg			18. Mother's Name (First, Middle, Maiden Surname) Gussie Bernstein			
19a. Informant's Name/Relationship (Type, Print) Walter Schwartz-Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1135 Dickens Street Far Rockaway, NY 11691				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Beth Moses Cemetery		20c. Date 01/31/2007		
21. Signature of Funeral Service Licensee <i>John Williams</i>		22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike Rockville, MD 20852				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of): c. _____ d. _____						
Approximate Interval Between Onset and Death						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>Patricia Tomsko Nay, MD</i>						
29c. License number D51916						
29d. Date signed (Month, Day, Year) Jan. 30, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Patricia Tomsko Nay, 1119 Rockville Pike, G-100, Rockville, MD 20852</i>						
31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature <i>Debbie B. Jacobs</i>				

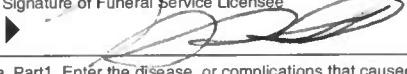
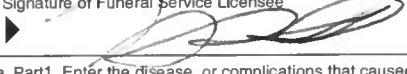
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

04490

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Sylvia K. Saks						2. Date of Death Month Day Year January 29, 2007	3. Time of Death 6:33 A M
		4a. Facility Name (If not institution, give street and number) 3118 Gracefield Road #519			4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 154-01-4419		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 2/7/1917	9. Birthplace (State or Foreign Country) NJ
		Usual Residence of Decedent 10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director		10e. Street and Number 3118 Gracefield Road #519			10f. Zip Code 20904			10g. Citizen of What Country? United States	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year of Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White	
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Job Placement College Coordinator			16b. Kind of Business/Industry Education	
		17. Father's Name (First, Middle, Last) Harry Kahn			18. Mother's Name (First, Middle, Maiden Surname) Golda Schulman Kahn				
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type. Print) Marilyn Saks-McMillion - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 F Street N.E. Washington DC 20002				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Lebanon Cemetery			Date 2/1/07	20c. Location - City or Town, State Adelphi, MD
Physician /Medical Examiner		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23b. Approximate Interval Between Onset and Death weeks				
Physician /Medical Examiner		23c. Due to (or as a consequence of): a. Acute Myelomonocytic Leukemia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year	
Physician /Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Physician /Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
Physician /Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) _____ _____			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 				
Physician /Medical Examiner		29c. License number D34590			29d. Date signed (Month, Day, Year) January 29, 2007				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy E. Fried MD 3110 Gracefield Road Silver Spring MD 20904							
Baltimore, Maryland 21215-0036		31. Date filed (Month, Day, Year)			32. Registrar's Signature				

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the physician's signature has been recorded on the death certificate, the physician shall give the death certificate to the funeral director for delivery to the deceased person's family.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 0449
Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, W

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death		
		ROBERT ELMER STONESTREET		Month Day Year		JANUARY 29, 2007 3:15AM M		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
WASHINGTON ADVENTIST HOSP.		TAKOMA PARK		PRINCE GEORGE'S				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)	
213-46-8619		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	67 Yrs.	Months	Days	(Month, Day, Year)	AUG. 10, 1939 MARYLAND	
Usual Residence of Decedent								
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits		
MARYLAND	PRINCE GEORGE'S	AQUASCO				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
20125 AQUASCO ROAD		20608		U.S.A.				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 10		College (1-4 or 5+) MAINTENANCE WORKER		SOUTHERN MD OIL CO.				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)						
JOSEPH ELMER STONESTREET		FRANCES MABEL JENKINS						
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
M. LUCY STONESTREET-WIFE		20125 AQUASCO RD., AQUASCO, MD 20608						
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		ST. MARY'S CHURCH CEM. 2-3-07		RAYMOND FUNERAL SERVICE, P.A.		ERYANTOWN, MD		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility						
<i>Dale</i>		LA PLATA, MARYLAND 20616						
22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.						Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)		a. Myocardial Failure Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Coronary Artery Disease Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)						
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dale Argus Dazi</i>		29c. License number 28883		29d. Date signed (Month, Day, Year) 1-29-07				
30. Name and address of person who completed the cause of death (Item 23a) (Type, Print)								
Dr. Argus Dazi 7610 CARROLL AVE TAKOMA PARK, MD 20912								
31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature <i>Steve B. Smith</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00

202

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Sandra Diane Souders						2. Date of Death Month Feb Day 6 Year 2007	3. Time of Death 545 P M		
Funeral Director		4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington			
To Be Completed by Funeral Director		5. Social Security Number 219-66-0197		6. Sex 1□M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 2, 1955	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Physician/Medical Examiner		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Myersville			10d. Inside City Limits 1□Yes <input checked="" type="checkbox"/> No		
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036		10e. Street and Number 11226 Pleasant Walk Road			10f. Zip Code 21773			10g. Citizen of What Country? USA			
Physician /Medical Examiner		11. Marital Status 1□Never Married 2 <input checked="" type="checkbox"/> Married 3□Widowed 4□Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1□Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one.		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Custodian		16b. Kind of Business/Industry Frederick County School Board					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Walter William Wolfe, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Sarah Virginia Gossard						
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print) Larry E. Souders/husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11226 Pleasant Walk Road, Myersville, MD 21773						
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2□Cremation 3□Removal from State 4□Donation 5□Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Walk U. Meth.		Date Feb. 9, 2007	20c. Location - City or Town, State Myersville, Maryland				
To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee <i>Patricia L. Souders</i>		22. Name and Address of Facility Ricketts Funeral Home			504 Main Street Myersville, MD 21773				
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
		<p>a. Due to (or as a consequence of): <i>Ovarian Cancer</i> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 15 months</p>									
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Yes 2 <input checked="" type="checkbox"/> No 9□Unknown		23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3□Ectopic pregnancy 4□Pregnant at time of death 5□ Other (specify) _____			23d. Date of delivery Month Day Year				
To Be Completed by Funeral Director		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1□Yes 2 <input checked="" type="checkbox"/> No 3□Probably 4□Unknown				
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1□Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2□ER/Outpatient 3□DOA Other: 4□Nursing Home 5□Residence 6□Other (Specify)			24a. Was an autopsy performed? 1□Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1□Yes 2□No	
To Be Completed by Funeral Director		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5□Pending investigation 2□Accident 6□Could not be determined 3□Suicide 4□Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1□Yes 2□No	28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To Be Completed by Funeral Director		29b. Signature and title of certifier <i>Michael McCormack MD</i>		29c. License number 041667			29d. Date signed (Month, Day, Year) 2-6-07				
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael McCormack 1110 Medical Campus Hagerstown MD</i>									
State Registrar		31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature <i>Debra A. Smith</i>							

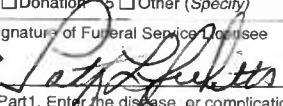
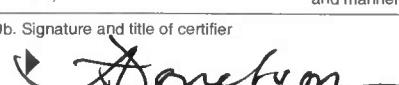
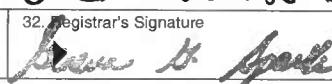
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04493

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LENA LEVIRL SHEPLEY					2. Date of Death Month Day Year February 6 2007	3. Time of Death 11:50 A M	
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL		4b. City, Town, or Location of Death FREDERICK			4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 212-38-8979	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 28, 1916	9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent 10a. State Maryland		10b. County Frederick			10c. City, Town or Location Walkersville		
To Be Completed by Funeral Director	10e. Street and Number 10134 Dublin Road			10f. Zip Code 21793		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give <input checked="" type="checkbox"/> Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Edward Blaine Blickenstaff			18. Mother's Name (First, Middle, Maiden Surname) Mabel Susan Kline				
	19a. Informant's Name/Relationship (Type, Print) Judith L. Burrier/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10098 Woodchuck Lane, Frederick, Maryland 21702					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grossnickle Brethren		Date Feb. 9, 2007	20c. Location - City or Town, State Myersville, Maryland		
	21. Signature of Funeral Service Director 		22. Name and Address of Facility Ricketts Funeral Home		23. Date of delivery Month Day Year			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 7 DAYS					
	a. Due to (or as a consequence of): CEREBRAL VASCULAR ACCIDENT							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CAD, HYPER TENSION, DEMENTIA							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  A. JONESON		29c. License number 221936		29d. Date signed (Month, Day, Year) 2/17/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. JONESON 65C THOMAS JONSON JR. FREDERICK, MD 21702							
State Registrar	31. Date filed (Month, Day, Year) FEB 14 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, <

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04494

1 - For
State
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHUCHI YABUT VEHEMENTE						2. Date of Death Month Day Year JANUARY 25, 2007	3. Time of Death 12:25 AM		
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL			4b. City, Town, or Location of Death OLNEY			4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number 213-84-0351		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 09/13/1948	9. Birthplace (State or Foreign Country) PHILIPPINES			
	Usual Residence of Decedent		10a. State MARYLAND 10b. County MONTGOMERY			10c. City, Town or Location OLNEY				
To Be Completed by Funeral Director	10e. Street and Number 17909 GAINFORD PLACE			10f. Zip Code 20832		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 4		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. ASIAN			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME					
	17. Father's Name (First, Middle, Last) ANASTACIO YABUT			18. Mother's Name (First, Middle, Maiden Surname) ELADIA MAGTALAS						
	19a. Informant's Name/Relationship (Type, Print) VIRGILIO P. VEHEMENTE - SPOUSE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17909 GAINFORD PLACE, OLNEY, MARYLAND 20832						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) GATE OF HEAVEN CEMETERY		20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY		Date 1/31/2007	20c. Location - City or Town, State SILVER SPRING, MARYLAND				
	21. Signature of Funeral Service License B. REUTTER & Son, CFSP		22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death MINUTES			
	<p>a. ARRHYTHMIA Due to (or as a consequence of):</p> <p>b. DEHYDRATION Due to (or as a consequence of):</p> <p>c. BREAST CANCER W/LUNG & BRAIN METASTASIS Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DIABETES MELLITUS						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one) 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier M.D. 29c. License number D0058770 29d. Date signed (Month, Day, Year) 30 January 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEREMY GRAF, M.D., 18101 PRINCE PHILIP DRIVE, OLNEY, MARYLAND 20832									
State Registrar	31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature James L. Jones							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 04495

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Lee Hobbs Wurtz					2. Date of Death Month Day Year January 28, 2007	3. Time of Death 4:45 pM						
	4a. Facility Name (If not institution, give street and number) 9205 Summit Rd			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery							
Funeral Director	5. Social Security Number 217-18-2010		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 11, 1919	9. Birthplace (State or Foreign Country) Maryland					
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 9205 Summit Road			10f. Zip Code 20910		10g. Citizen of What Country? USA							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Homemaker		16b. Kind of Business/Industry Own Home								
	17. Father's Name (First, Middle, Last) Diane Burt				18. Mother's Name (First, Middle, Maiden Surname) Annette Purcell Stoneham								
	19a. Informant's Name/Relationship (Type, Print) Diane Burt/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6300 Town Point Road, Tracy's Landing, MD 20779									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Colesville United Methodist Church		Date February 2 2007	20c. Location - City or Town, State Silver Spring, Maryland							
	21. Signature of Funeral Service Licensee Andrew Cole		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death None				
	<p>a. Due to (or as a consequence of): ASCVD</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)						23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D00428						29d. Date signed (Month, Day, Year) Jan. 29 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRV BRECHER, MD OME								31. Date filed (Month, Day, Year) JAN 31 2007				
Medical Certification: To Be Completed by Physician/Medical Examiner	32. Registrar's Signature IRV BRECHER, MD OME								33. Date signed (Month, Day, Year) Jan. 29 2007				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. _____

007 496

Baltimore, Maryland 21215-0036									
Division or Vital Records, P.O. Box 68760,									
Physician /Medical Examiner									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.									
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit									
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.									
State Registrar									
To Be Completed by Physician/Medical Examiner									
To Be Completed by Funeral Director									
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year						3. Time of Death	
LILLIAN S. WALLACE		JAN. 25, 2007						6:00 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death						4c. County of Death	
30 Norwood Road		Silver Spring						MONTGOMERY	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 4, 1918	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent		10c. City, Town or Location						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MD	10b. County Montgomery	Silver Spring							
10e. Street and Number 30 Norwood Road		10f. Zip Code 20905						10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 yrs			16b. Kind of Business/Industry Montg. Co. Schools				
17. Father's Name (First, Middle, Last) Thomas E. Snowden, Sr		18. Mother's Name (First, Middle, Maiden Surname) Lenna Hill							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Wallace (Husband) 30 Norwood Road, Silver Spring, MD 20905							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Bonita A. Snowden Jr.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Mem. Park			Date 2/2/07	20c. Location - City or Town, State Olney, MD			
21. Signer/Lic. of Funeral Service License		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) Dementia									
Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Godswill Okojil, M.D.</i>		29c. License number D050545						29d. Date signed (Month, Day, Year) 1/29/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Godswill Okojil, M.D. 7513 New Hampshire Ave. Takoma Park, MD 20912									
31. Date filed (Month, Day, Year) JAN 31 2007		32. Registrar's Signature <i>Bonita A. Snowden Jr.</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04497

1- For State
RegistrarPhysician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LUCILE ELIZABETH OFFUTT WALTER	February 6, 2007	2325 hrs

4a. Facility Name (if not institution, give street and number)
Northwest Hospital4b. City, Town, or Location of Death
Randallstown4c. County of Death
Baltimore CountyFuneral
Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	B. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
219-48-6386	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	53 Yrs.	Months	Days	JULY 30 1953	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
MD	BALTIMORE	RANDALLSTOWN	

10e. Street and Number
8 WILLOW BROOK CT.10f. Zip Code
2113310g. Citizen of What Country?
USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:		

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE	16b. Kind of Business/Industry DOMESTIC
2			

17. Father's Name (First, Middle, Last)

LEONARD JEROME OFFUTT
DAVID WALTHER / SPOUSE

18. Mother's Name (First, Middle, Maiden Surname)

MARY LORETTA DAVIS
8 WILLOW BROOK CT., RANDALLSTOWN, MD 21133

19a. Informant's Name/Relationship (Type, Print) DAVID WALTHER / SPOUSE	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	21133
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MARY'S CATHOLIC CHURCH CEMETERY
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	Date 2/12/07
21. Signature of Funeral Service Licensee <i>David Walther</i>	20c. Location - City or Town, State BARNESVILLE, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <u>Combined doxepin and oxycodone intoxication</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED #28,27,28a-f, per ME, G864, 2/21/07 TT
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other	26. Place of Death (Check only one)
---	--	-------------------------------------

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Fnd 2/6/2007	28b. Time of Injury unknown	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred subject ingested drugs
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence			28f. Location (Street and Number or Rural Route Number, City or Town, State) 8 Willow Brook Court Randallstown, MD

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 7, 2007
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30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
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31. Date filed (Month, Day, Year) FEB 15 2007	32. Registrar's Signature <i>Ling Li, MD</i>
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 04498

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Marguerite Waldron						2. Date of Death Month Day Year February 4, 2007	3. Time of Death 21:55 M
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center			4b. City, Town, or Location of Death Leonardtown			4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 577-09-1595		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 23, 1919	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Piney Point			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 16124 Thomas Road			10f. Zip Code 20674			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Computers				
17. Father's Name (First, Middle, Last) Harry Leonard Robrechet				18. Mother's Name (First, Middle, Maiden Surname) Florence Rosella Poe				
19a. Informant's Name/Relationship (Type, Print) Barbara Raley / Cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27337 Tin Top School Road, Mechanicsville, Maryland 20659				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Michael B. Gardiner</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Francis Xavier Cemetery		Date February 8, 2007	20c. Location - City or Town, State St. George's Island, MD			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650						
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Respiratory Failure b. Due to (or as a consequence of): Myocardial Infarction c. Due to (or as a consequence of): Coronary Artery Disease</p> <p>Approximate Interval Between Onset and Death hr.</p> <p>d.</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia, C.O.R.D.</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number JAMES P. JARBOE M.D. D 06419						
29b. Signature and title of certifier <i>James P. Jarboe M.D.</i>		29d. Date signed (Month, Day, Year) 2-5-07						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D.		31. Date filed (Month, Day, Year) FEB 06 2007						
		32. Registrar's Signature <i>Leanne B. Spangler</i>						

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 04499

1 - For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death		
CYNTHIA WESTWOOD			Month	Day	Year	M		
WMHS-BRADDOCK CAMPUS			01	26	2007	1431		
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
WESTWOOD			CUMBERLAND			ALLEGANY		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)	
217-82-2317		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	43 Yrs.	Months	Days	Hours	Min.	September 18, 1963 Maryland
Usual Residence of Decedent								
10a. State	10b. County	10c. City, Town or Location						10d. Inside City Limits
Maryland	Allegany	Mount Savage						<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
14123 Upper Sunny Side Road, NW			21545-			U.S.A.		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White	
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
Elementary/Secondary (0-12) 10		College (1-4 or 5+) 0		homemaker			homemaker	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
Kenneth Ritchey, Sr.				Pauline Norris				
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Pauline Ritchey mother			P O Box 17 Hyndman Pennsylvania 15545					
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			Cumberland Crematory			January 29, 2007	Cumberland Maryland	
21. Signature of Funeral Service Licensee			22. Name and Address of Facility					
			Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

18 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. HEPATIC FAILURE

Due to (or as a consequence of):

b. SEPTIC SHOCK

Due to (or as a consequence of):

c. PNEUMOCOCCAL PNEUMONIA

Due to (or as a consequence of):

2 Days

3 Days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATIC CIRRHOSIS

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown25. Was case referred to medical examiner?
1 Yes 2 No27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

26. Place of Death (Check only one)

Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work?
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 25406

29d. Date signed (Month, Day, Year)

JANUARY 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Lamm M.D.

900 Seton Drive Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JAN 29 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

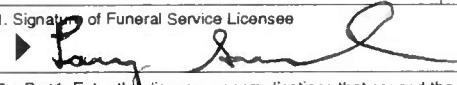
State of Maryland / Department of Health and Mental Hygiene

1- For Amend #23a,28e-f, per ME, g865, 3/1/07
Registrar

Certificate of Death

Reg. No.

2007 04500

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Judge Williams						2. Date of Death Month 01 Day 25 Year 2007	3. Time of Death 6:40pmM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578-72-0214	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) 03/14/48	9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent 10a. State Md 10b. County P.G. 10c. City, Town or Location Greenbelt 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Funeral Director	10e. Street and Number 6512 Lake Park Dr #104			10f. Zip Code 20770			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 year				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician				16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Charles R. Williams Sr.					18. Mother's Name (First, Middle, Maiden Surname) Bettie K. Kemp				
19a. Informant's Name/Relationship (Type, Print) Alneta Williams Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6512 Lake Park Dr #104 Greenbelt, Md 20770					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery			Date 02/03/07	20c. Location - City or Town, State Washington, DC	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Snead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Bowie, Maryland					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACCIDENTAL HIP AND ANKLE FRACTURE								Approximate Interval Between Onset and Death 20721
	Immediate Cause (Final disease or condition resulting in death) RENAL SEQUELAE FROM STOKE								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. RENAL SEQUELAE Due to (or as a consequence of):</p> <p>b. RENAL SEQUELAE FROM STOKE Due to (or as a consequence of):</p> <p>c. CORONARY ARTERY DISEASE Due to (or as a consequence of):</p> <p>d. RENAL SEQUELAE FROM STOKE Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month 2 Day 1/07 Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) 12/01/06		28b. Time of Injury 9:15 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred FALL AT WORK	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) CHURCH		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1200 ISLE OF PANTOS PLAZA							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number MS57614							
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 1/30/07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.M. Colombe 4600 Carroll Ave. Takoma Park MD									
31. Date filed (Month, Day, Year) FEB 01 2007		32. Registrar's Signature 							